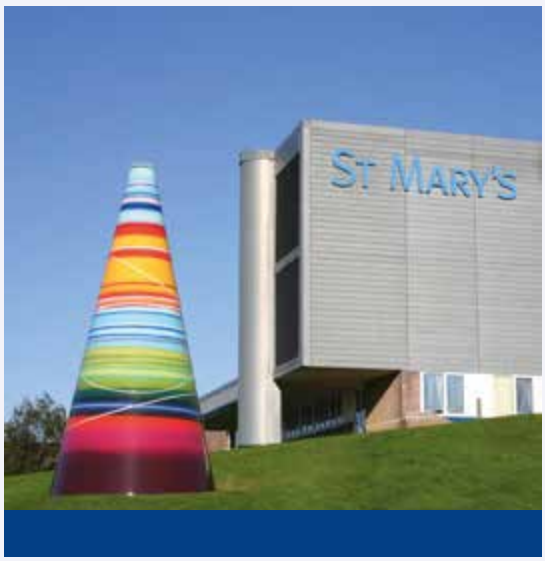
NHS
Isle of Wight
NHS Trust



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TeAm Working
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Isle of Wight NHS Trust

Quality Account

2018 – 2019

Contents

What is a Quality Account?

What is a Quality Account?

The Quality Account is an annual report published to the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and outlines what the Trust will focus on in the next year.

What should a Quality Account look like?

Some parts of the Quality Account are mandatory and are set out in accordance with the NHS (Quality Account) Regulations 2010 and Department of Health – Quality Accounts Toolkit 2010/2011). This toolkit can be accessed via https://www.gov.uk/government/news/quality-accounts-toolkit

The Quality Account must include:

Part One (introduction)

- A statement from the Board of the organisation summarising the quality of NHS services provided.
- A review of performance against 2018/19 priorities.

Part Two (Organisation priorities for quality improvement for the financial year 2019/20)

- A series of assurance statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit.

Part Three (A review of the quality performance of services in the organisation for the previous financial year 2018/19)

- This must be presented under three domains; patient safety, clinical effectiveness and patient experience.

Part Four (annexes)

- A series of statements from Stakeholders on the content of the Quality Account.

Providers are able to add additional sections and information, however, the Quality Account must have an introduction, it must then look back at previous performance and then look forward at the priorities for the coming financial year.

What does it mean for Isle of Wight NHS Trust?

The Quality Account allows NHS healthcare organisations such as Isle of Wight NHS Trust to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities. It also enables review of how the organisation performed in various other quality areas including service delivery. Finally it ensures that the Trust informs the public of its future quality plans and priorities.

What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Accounts should assure the Trust's patients, members of the public and its stakeholders that, as an NHS healthcare organisation, it is scrutinising each and every one of its services, providing particular focus on those areas that require the most attention.

How will the Quality Account be published?

In line with legal requirements all NHS Healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 28th June 2019. Isle of Wight NHS Trust also makes its Quality Account available on the website http://www.iow.nhs.uk/about-us/corporate-documents/

Part One

Introducing our Quality Account

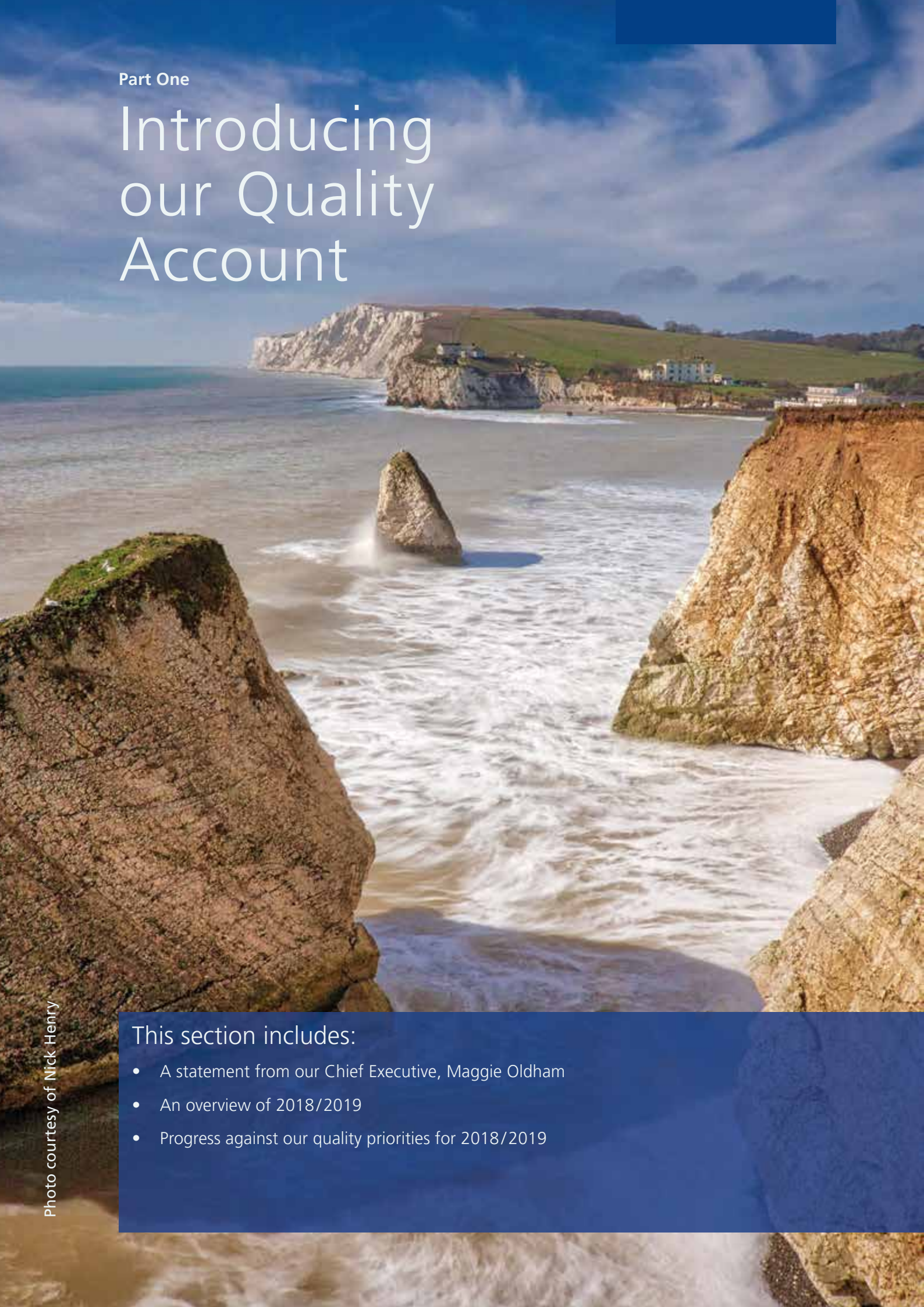


Photo courtesy of Nick Henry

This section includes:

- A statement from our Chief Executive, Maggie Oldham
- An overview of 2018/2019
- Progress against our quality priorities for 2018/2019

Introduction

Welcome to the Isle of Wight NHS Trust's Quality Account

The Isle of Wight NHS Trust is the only integrated acute, community, mental health and ambulance health care provider in England. Established in April 2012, the Trust provides a full range of health services to an isolated offshore population of circa 143,000.

Acute Care Services

Based at the heart of the Island, with 274 beds and handling 32,794 admissions each year, St Mary's Hospital in Newport is our main base for delivering acute services for the Island's population. Services include Accident and Emergency (A&E), the Urgent Care Service (by referral only), Emergency medicine and surgery, planned surgery, intensive care, comprehensive maternity, Neonatal Intensive Care Unit (NICU) and paediatric services with 1,065 births last year. Within our Acute services, a number of planned care services including chemotherapy and orthopaedics are also delivered.

Ambulance Service

The Ambulance Service consists of the operational delivery units for the 999 emergency ambulances, NHS111, Emergency Planning Resilience and Response, Patient Transport Services (PTS), and Community First Aid Training. Last year the service handled 17,760 emergency calls, 82,987 NHS 111 calls, 30,403 emergency vehicle dispatches, and 10,908 PTS journeys and trained over 4000 members of the public in life saving skills. St Mary's Hospital in Newport houses the Island's ambulance station, combined 999 control room and NHS 111 services and patient transport service providing a service to the Island's 140,000 residential community as well as the tourist population which sees the population rise to 220,000 in summer. This sees the service ensuring safe transfer of both emergency and non-emergency patients to the mainland.

Community Care Services

Community Services within the Trust range from supported care within a patient's home, to physiotherapy and podiatry support within the Acute setting. The Community Division supports the three localities of the Isle of Wight: North, West & Central, and South East with District Nursing facilities in each area. There is also consistent support offered for Children and Young People through the 0–19 Service, consisting of Health Visitors and School Nurses. The Community Division is extensive and their support stretches across the Island, through various sites, children's centres and schools, and is an integral part of the Isle of Wight NHS Trust.

Mental Health Services

Our Mental health services provide inpatient and community based mental health care. We have 36 beds for working age and older adults, supported by a home treatment team, 10 mental health rehabilitation beds, and a community mental health team supporting a caseload of 1,700 service users. The service also includes community Child and Adolescent Mental Health Services (CAMHS), the Early Intervention in Psychosis team, primary care psychological therapies, community reablement services and the Memory clinic. We also provide community learning disability services.

Presentation

The Quality Account is presented in three parts:

Part One: is a statement from the Chief Executive of the Trust. This statement also includes the Trust's performance against 2018/19 priorities.

Part Two: sets out the organisation's priorities for quality for 2019/20. It also includes a series of statements about the organisation in areas such as clinical audit, research and data quality.

Part Three: reviews performance over the last twelve months in terms of patient safety, quality and effectiveness. It also illustrates some of the indicators the Trust Board has used to monitor progress throughout the year.

The formatting and sequencing of this document are in accordance with the National Health Service (Quality Accounts) Regulations 2010 and Department of Health (DOH) Quality Accounts Toolkit 2010/11.

Statement on Quality from the Chief Executive

Welcome to Isle of Wight NHS Trust's 2018/19 Quality Account

I am pleased to present the Quality Accounts for 2018/19, my first full year as Chief Executive. The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2019/20.

The last twelve months have certainly been challenging. I am truly humbled by the resilience of our dedicated staff and their commitment to continually do their best for patients and those who use our services. We started the year in April 2018 by formally approving our Quality Strategy to share our ambitions for improvement over the next couple of years and our aim of 'getting to good by 2020'. Since that time, all four of our services have developed local quality strategies to ensure the key priorities at Trust-wide level can be delivered at service level.

In November 2018, we formally approved our Trust's vision and values. These were developed following consultation and engagement with over 600 staff! All of those involved agreed that it is actually living the values and bringing them to life that is important.

Through our leadership and development programme we have been helping to support our staff in being compassionate leaders. I believe this is essential to continue to improve both staff morale and the services we provide.

We consulted with a wide range of stakeholders to agree the quality account priorities for 2019/20. These are:

- **Patient safety:** releasing time to care. We will identify and implement information systems that make it easier for our staff to realise improvements in patient safety through having more time available to provide care.
- **Clinical effectiveness:** right person, right place, right time. This was a priority last year that was not met in full. Our stakeholders told us that this is too important not to achieve and we agree. Our aim is for care to be provided at the right time and in the right place, which is not necessarily in hospital.
- **Patient experience:** dementia care. With our population group and the need for partnership working across the Island, everybody agreed that dementia care needed to be a priority. Whilst there have been improvements throughout 2018/19 with the introduction of our memory room and ward based bus stops, there is so much more we can do to make the Island dementia friendly.

I can confirm that the Trust Board has reviewed the 2018/19 Quality Accounts and can confirm, to the best of my knowledge, the information within this report is accurate and provides a balanced account of the quality of services we provide.

I hope that you enjoy reading this year's Quality Account.

Maggie Oldham
Chief Executive

Date: 24 May 2019

Overview of 2018/2019 Celebrating Success

The following table provides an overview of our successes during 2018/19. Some of the year's highlights include:

APRIL 2018

Executive team more accessible thanks to relocation

The Trust's Executive Team has relocated to a more accessible open-plan space in the centre of St Mary's Hospital.

MAY 2018

New initiative to provide more coordinated care for patients

The Trust has launched a new initiative with care homes on the Isle of Wight to provide more joined-up care for patients who are transferred to hospital. 'Red Bag' is an initiative designed to ensure a single patient record is shared between the Trust and care homes and is being piloted with 18 care homes across the Island. The pilot is due to finish in May and will then be reviewed before rolling out more widely.

JUNE 2018

New Theatre Admissions Lounge open

Patients coming into hospital for planned inpatient surgery will now be admitted directly to the Theatre Admissions Lounge for medical assessments and examinations.

JULY 2018

Service will celebrate 70 years of the NHS

All NHS staff across the Island, everyone involved in health and wellbeing services and members of the public are invited to attend. The service is supported and led by the Chaplaincy Team at Isle of Wight NHS Trust and will feature the Island's NHS Nightingales Choir. NHS staff who wear uniform to work are asked to attend in uniform to provide a sea of colour across the church.

As part of these celebrations St Mary's hosted a Health Innovation Forum with Wessex Academic Health Science Network (AHSN) inviting speakers from around the world to discuss how they planned to change healthcare.

AUGUST 2018

South Central Ambulance Service NHS Foundation Trust & Isle of Wight NHS Trust to explore further collaboration

South Central Ambulance Service NHS Foundation Trust (SCAS) and Isle of Wight NHS Trust (IWNHS) have announced that they are seeking opportunities to collaborate in a number of common areas.

SEPTEMBER 2018

Heritage Open Day

This will be a small event this year but we hope it will be the first of many years participation in Heritage Open Days so that we can share the rich history of the Island's health and care services.

OCTOBER 2018

Solving our Nursing Workforce Challenges through Apprenticeships

Donna Parkinson and James Barclay attended the South Regional Workforce Conference on the 8th November 2018 hosted by NHS Improvement, NHS England and Health Education England to present our project to implement Nursing Apprenticeships.

NOVEMBER 2018

New 999 ambulance Computer Aided Despatch (CAD) system for Island

Isle of Wight Ambulance Service, part of Isle of Wight NHS Trust, has successfully implemented a new Computer Aided Dispatch (CAD) system. The new system replaces CAD software which had been in use for nine years.

DECEMBER 2018

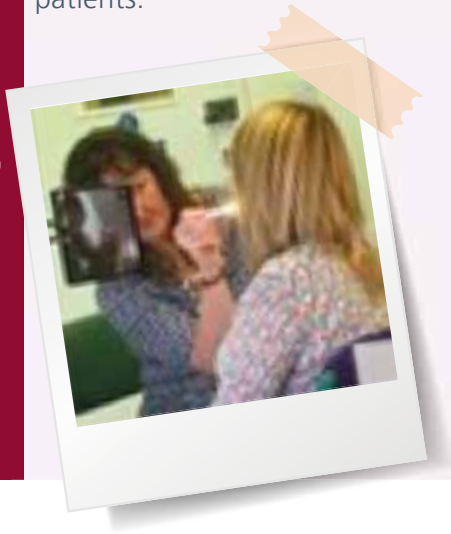
Isle of Wight Ambulance Service offers free CPR training to Island school children

This comes as the Education Secretary, Damian Hinds, announced that all children in England are to be taught CPR as part of the school curriculum by 2020. The basic lifesaving skills are part of Government plans for health education to be taught in every school, strengthening the teaching of health, sex and relationships education.

JANUARY 2019

Isle of Wight NHS Trust in Forefront of Digital Technology Use

Did you know that out of the 5,000 care homes in the UK, 74% of their residents have swallowing difficulties. Because of this a new digital diagnostic tool, 'Teleswallowing', is being trialled by the Isle of Wight NHS Trust. This trial will enable our Speech and Language Therapists (SLTs) to remotely diagnose swallowing difficulties in care home patients.



FEBRUARY 2019

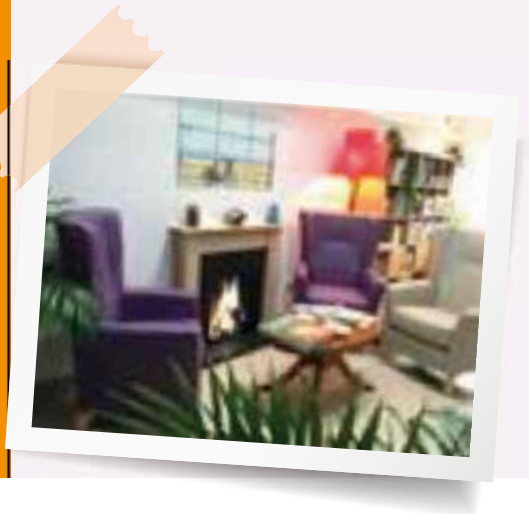
Better care for those nearing End of Life

Patients nearing the end of their lives and their friends and family will now have better access to the highest quality of care and support, thanks to the combining of two previously separate teams based at St Mary's Hospital (the hospital Palliative Care Team and the End of Life Care Team), creating one service – the Integrated Palliative and End of Life Care team (IPET).

MARCH 2019

New Dementia Lounge for patients of St Mary's

This Lounge has been specifically designed to create a relaxing and welcoming environment. With its homely and familiar features, the room offers a very different place for patients who may otherwise spend their days in bed on hospital wards.



Performance against 2018 / 19 priorities

PRIORITY ONE: patient safety – deteriorating patient

Our goal is to recognise deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them.

What we did:

- The Trust has continued to review and strengthen the governance arrangements for recognising and responding to acute deterioration in patients. We have made improvements to Datix, our incident reporting system. Having a system to capture safety incidents is critical in helping us learn and develop ways to make our services safer. Over time we recognised that the current Datix system required significant improvements to make it more relevant for certain services, and improve the user experience. We recognised that on reviewing the category of incidents it was not always clear as to whether the incident referred to the deteriorating patent. Therefore from the 1st April 2019, the category of the deteriorating patient has now been added to the Datix Incident reporting system in order to capture this data accurately, which will increase its value and our learning.
- We are also continuing to embed systems and processes for recognising and responding to acute deteriorating patients. The National Early Warning Score (NEWS2) has been implemented within the Trust because evidence shows that early warning systems increase attention to regular observations for patients.
- We put in place a NEWS2 implementation group to achieve full implementation of NEWS2 across all our services before the 31st March 2019. The Trust went live on the 15th December 2018 in community, acute, ambulance and mental health services. The Trust was the first in the Wessex region to fully implement NEWS2 in all community, acute, ambulance and mental health services.
- We have set up a new monthly auditing process of NEWS2 compliance across all services that use NEWS2.
- The Critical Care Outreach Service (CCOS) implemented the 'Call for Concern'. This service enables visitors and/or patients to highlight any concerns about their condition to CCOS directly. This ensures the soft signs of deterioration to be reported and acted on in a timely manner.
- Critical Care Outreach has expanded their sepsis liaison service and this now covers maternity and paediatric services.
- Two Acute Illness Management (AIM) courses have been run on the Isle of Wight this year for new junior doctors and acute healthcare professionals.
- The integrated sepsis policy has been updated to reflect new evidence-based approaches to sepsis. It outlines our approach to sepsis screening and treatment in the Trust.
- The Isle of Wight Ambulance Service has revised their pre-hospital antibiotic protocol and they continue to give intravenous antibiotics to patients in their own home if they meet the sepsis criteria.
- Sepsis recognition and response pocket guides have been developed and given to key staff to raise awareness of the local process.
- We were successful in securing a League of Friends bid to buy manual blood pressure monitoring equipment for each acute care area to support effective patient monitoring and detection of deteriorating patients.
- A new deteriorating patient e-learning package has been launched. This includes the new sepsis recognition and response process for all clinical staff.
- A new initiative called 'Time to Act' has been launched, led by the CCOS sister, it brings together a multi-disciplinary group of staff to champion the deteriorating patient agenda in clinical areas.
- The Isle of Wight is an active member of the deterioration and sepsis network which is hosted by the Wessex Academic Health Sciences Network (AHSN).
- The Resuscitation Service has launched cardiac arrest huddles. These take place on a daily basis during the hospital at night meetings. During these huddles the teams allocate roles to specific team members in the event of a cardiac arrest.
- The implementation of an Acute Kidney Injury (AKI) care bundle sticker to promote consistent care for this patient group.
- New in-patient intravenous and fluid charts were developed and implemented in line with NICE guidance.

Outcomes

The following table provides performance data against the targets:

Indicator	2018 Target	Achievement
Trust NEWS2 compliance	90%	**75%**
In-patient cardiac arrests resulting in a serious incident	25% reduction (10 occurred)	**28% reduction**
Readmission to Intensive Care Unit (ICU) within 48 hours	20% reduction	**20% reduction**
Serious incidents linked to failing to recognise the deteriorating patient (data from more than one Strategic Executive Information System (StEIS) category e.g. delay in treatment & sub-optimal care of deteriorating patient)	25% reduction (32 occurred)	**Not Achieved (43 incidents)**
Sepsis 6 compliance	90%	**85% Compliance**
Compliance with Acute Kidney Injury (AKI) bundle sticker once ward phoned with a positive AKI result from the lab	50%	**48%**
Fluid chart compliance	80%	**40% Compliance**

Key	
	Achieved in full
	Improvements made
	Not met

The Clinical Standards Sister has piloted a new hydration chart which is supported by guidance. This guidance ensures staff are able to ascertain which patients require a hydration chart and which patients require a fluid balance chart.

The pilot ran for three weeks in May and was supported by the Clinical Standards Sister and Practice Development Facilitator.

All nursing staff and the ward housekeepers will receive the appropriate and a weekly audit will be undertaken to monitor compliance.

The results will be displayed for all staff to see how well the team are doing and where improvements can be made.

To assist with compliance, visual aids will identify which charts are being used for each patient. Patients, who are able to, will have the chance to complete their own hydration charts, encouraging a more engaged care plan.

The results from the two pilot wards will be evaluated through staff feedback and audit results. The Trust will then review its fluid balance monitoring practices and, if the pilot is successful, implement the new charts and visual aids as the basis for future change on all acute wards/areas.

PRIORITY TWO: clinical effectiveness – right patient, right place, right time

Our goal is that all our patients are located in the most appropriate place from admission to discharge.

What we did:

- Patient discharge plans are now commenced on day one with patients engaged in the process at all times.
- A dedicated patient pathway navigation team is now fully operational on all wards to support patients and staff with discharge planning.
- New discharge planners have been introduced to patient notes creating a single point for communication.
- Consultant discharge stickers have been introduced to clearly identify when a consultant has deemed patients fit to leave an acute hospital bed; building better communication between teams.
- SAFER tool now embedded on all wards.
- Discharge consultants being developed to ensure that patients' needs are planned for and met against agreed time-frames.
- Improved seven day working to ensure discharge at weekends, inclusive of criteria-led discharge planning.
- Improved emergency planning to ensure that peak pressure times can be managed well.
- Ensured that all emergency patients are assessed within emergency care standard time and referred to the most appropriate speciality and place for treatment.
- Elective admissions include discharge planning at pre-assessment visit.
- Continued to improve both 'see and treat' and 'hear and treat' in the ambulance setting.
- Aimed to reduce the number of stranded patient's, >7/14/21 days with twice weekly senior management review, and once weekly executive oversight.
- Improved communication for handover and transfers of care through electronic transfer form.
- Introduced real time monitoring for incorrect placements with ward displays.
- Worked with partners to reduce Delayed Transfers of Care (people that are awaiting moves into residential/nursing care, home support, hospice etc.).
- The Trust has, over the past two years, been working on initiatives to improve patient experience. This includes a drive to ensure patients are located in the right place at the right time for their care.
- When someone is experiencing an illness we, as health professionals, acknowledge each patient's individuality and the unique way in which they experience a condition and how it impacts on their life.
- Patients' values, beliefs and circumstances all influence their expectations of, their needs for, and their use of, health services.
- Recognised the individuality of patients. This includes an appreciation that how they live with their conditions and the ways in which their family and broader life affect their health and care need to be taken into account.

Outcomes

- Outcomes for individuals, rather than numbers, are at the heart of discharge planning.
- All partners agreed to 'put their house in order' as well as work together to improve the system.
- The teams have operational autonomy to identify and implement solutions to effectively improve the system.
- There will be provision of extra capacity in the form of project leads and operational/clinical champions in order to ensure a concentrated effort on culture change and supporting behaviours.
- The profile of DTOCs has remained at a heightened level of scrutiny to ensure that challenges and successes for the system are learned from. This ensures continued learning across the system.

Earlier identification of patients with complex support needs once they are **'assessment fit'** (we need your support with this).

We should ask of every patient at every Board Round – **Why not home? Why not today?**

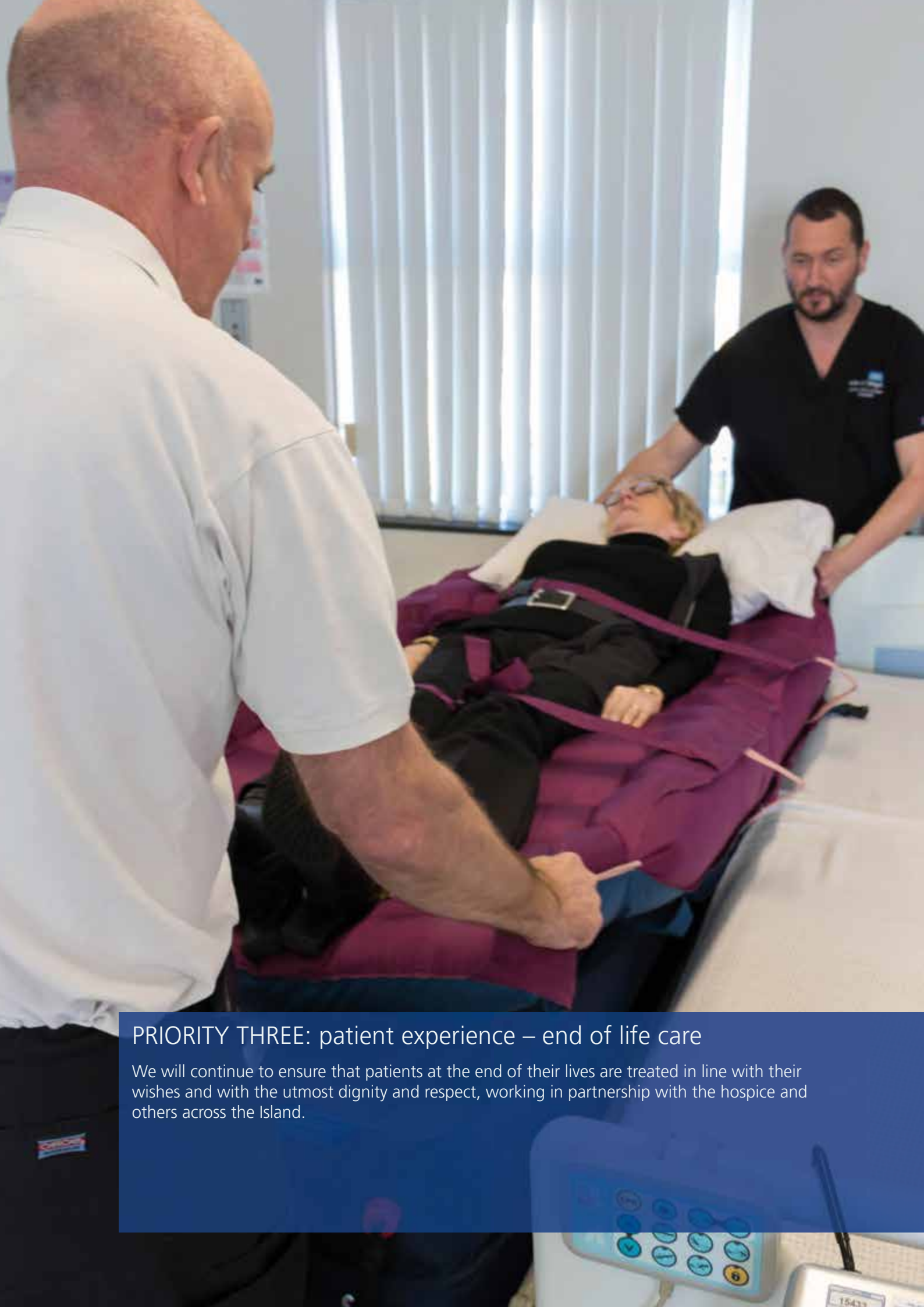
We are going to stop 'assessing to discharge' and instead **'discharge to assess'** so that we stop prescribing long term care needs during an acute stay.

We are going to **communicate clearly** and create an efficient and co-ordinated **discharge plan** showing that we are working together to address what matters to people.

The following table provides performance data against the targets:

Indicator	2018 Target	2017 / 18 Baseline	Achievement
Bed occupancy	90%	100%	**Year to date 94% Not met**
Stranded patients >7 days	98	150	**Year to date 122 Not met**
Stranded patients >21 days	41	55	**Year to date 44 Not met**
Readmission rates	5.0%	5.9%	**Year to date 6.3% Not met**
Out of hours transfers 22:00 – 06:00	98%	98%	**98% met**
Delayed transfer of care	146	2.700	**Not applicable**

Key	
	Achieved in full
	Improvements made
	Not met



PRIORITY THREE: patient experience – end of life care

We will continue to ensure that patients at the end of their lives are treated in line with their wishes and with the utmost dignity and respect, working in partnership with the hospice and others across the Island.

What we did:

- Signed a Memorandum of Understanding with Mountbatten Hospice to work in partnership with them.
- Developed a Trust 'End of Life Care' Strategy.
- Revised and updated the Priorities of Care document to reflect the changing needs of the patient.
- Amalgamated the hospital Palliative Care Team (Mountbatten staff) and the End of Life Care Team (Trust staff) to form one service – the Integrated Palliative and End of Life Care team (IPET).
- Changed our working hours to accommodate longer hours of service; now working 8am to 8pm Monday to Friday.
- Moved to one referral system with one bleep for all.
- Standardised syringe driver training across the Trust (a syringe driver is a small battery operated infusion device that can be used in hospital or at home to deliver drugs).
- Strengthened our governance processes and updated the functioning of the End of Life Operational Group monthly meetings.
- Improved data recording to provide robust evidence of performance.
- Identified end of life care 'champions' in each area, who hold monthly meetings; these encompass new training and developments.
- Purchased folding beds to enable patients to have those who are important to them alongside them in the last hours of life.
- Provide comfort bags for those who are comforting patients at the end of their lives. These bags contain essential basic items such as a toothbrush, toothpaste, soap etc.

Outcomes

The results of the latest National Audit of Care at the End of Life (NACEL) were released in February 2019. The audit aims to improve the quality of care for people at the end of their lives and monitors progress against five priorities, as set out in the National Institute for Health and Care Excellence (NICE) Quality Standard 144 (one chance to get it right), within the context of NICE Quality Standard 13 which addresses last years of life.

The audit included three components:

1. An organisational level audit.
2. A case note review which reviewed all deaths in April 2018.
3. A quality survey.

The results are detailed on the following page and demonstrate our performance against the national summary score.

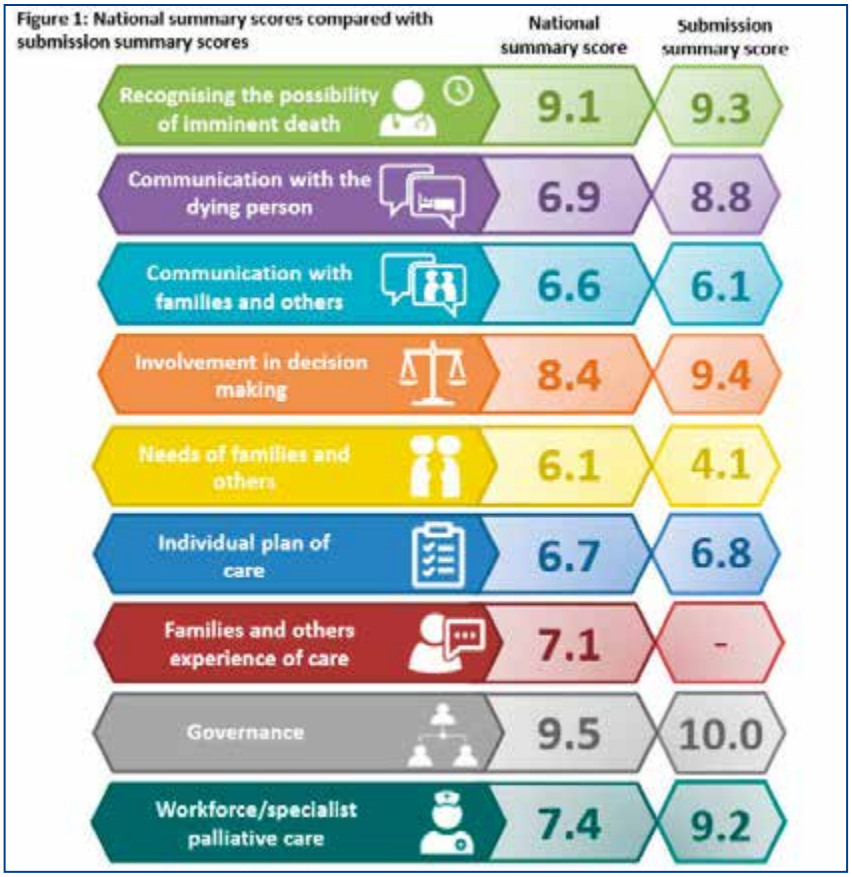
Of the nine domains identified on the following page, the Isle of Wight NHS Trust is better than the national average in six of these, with one not reported. We are only below national average in two domains.

In the year 2017/18, the End of Life Care service received only six complaints. The team have worked hard on trying to resolve issues as they occur, including the introduction of 'postcards' which can be completed whilst patients and those closest to them are still in hospital, enabling the staff to address any issues or concerns at the earliest opportunity.

From 1st April 2018, the service has received a total of four complaints, with only one having been received in the last six months.

Positive feedback from stakeholders:

On the 9th January 2019 we were pleased to host a stakeholder event specifically aimed at meeting patients and those closest to them, to enable us to share progress so far and to gain their feedback on our plans for the future. Despite talking about death, there was positive feedback both on the day and in emails afterwards. This was followed by a further event on 18th January, specifically targeted at staff but with patient/public involvement also. At this event we welcomed 87 people through the doors, and once again the feedback was very positive.



EOLC 2018	2018/19 Target	April 2018	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2019	Feb	March
Preferred point of care Identified/place of care met?	47%	Preferred point of care Identified 65.4%	Preferred point of care Identified 47.1%	Preferred point of care Identified 64.3%	Preferred point of care Identified 52.5%	Preferred point of care Identified 78.6%	Preferred point of care Identified 53.8%	Identified: 70.8% Of which 70.6% was met.	Identified 70.6% Of which 33.3% met.	Identified 68% Of which 64.7% where met	Identified 96% Of which 60% were met	Identified 65% Of which 31.3% were met	Identified 74.2% Of which 57.1% were met
All reported EOLC incidents	No baseline target	No data	No data	No data	No data	3	8	4	6	3	5	7	13
Formal complaints relating to EOLC	2	No Data	1	1	0	0	1	0	0	0	0	0	1
Time-frames met for responding to EOLC complaints	75%	No data	Yes	Yes	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	Yes
DNACPR compliance	100%	50%	100%	0% – no audits	0% – no audits	0% – no audits	100%	50%	100%	94%	100%	88%	90%

Part Two

Priorities for Improvement and statements of assurance from the board

This section includes:

Quality priorities for 2019/20

Statements of assurance from the Board (the contents of these statements are prescribed).

Statements include:

- Review of services
- Participation in clinical audit
- Participation in research
- Goals agreed with commissioners
- What others say about the Trust
- Data quality
- Learning from deaths

Quality Priorities for 2019/20

The Trust Board in consultation with key stakeholders, such as commissioners, Patients Council, Healthwatch and staff groups, has identified three overarching priorities for quality improvement during 2019/20. These priorities are derived from the Trust's performance over the past year against its quality and safety indicators and are outlined in the following sections:

PRIORITY ONE

Patient safety: releasing time to care

Goal

Our goal is to use technology to maximise the time clinicians spend with patients, improving safety and outcomes.

Why?

Our clinical staff tell us that they have in excess of 50 audits to complete to demonstrate standards are being achieved. Whilst this is important, time to provide care is more so. Many organisations have realised the benefits of engaging with clinicians to develop appropriate information systems and tools to aid continuous improvement.

Who?

The Director of Finance/Deputy Chief Executive leads on Information for the Trust. This will be a shared priority with the Director of Nursing, Midwifery, AHPs and Out of Hospital Services to ensure it supports the Patient Safety agenda.

How?

We will do this by:

- Implementation of an electronic tool for cleaning audits.
- Implementation of an electronic tool for health and safety audits.
- Identification of system for recording patient observations and improving compliance with the care of the deteriorating patient.

What is the Trust Board?

The Trust Board is the Board of Directors of the Trust, who are collectively accountable for the Trust. The Trust Board sets the strategic direction (the 'direction of travel') for the Trust over the coming years and ensures that the Trust has high standards in clinical care, financial stewardship, as well as responding to the health needs of the population it serves.

Every Trust Board is required to have a Chairman and a mix of Non-Executive and Executive Directors. The Non-Executive Directors, who make up the majority of the Trust Board, give an independent voice to the Trust Board and provide a high level of scrutiny to all aspects of the Trust. They bring to the Board a wide range of professional and business experience.

- Identifying other opportunities for information technology to release time to care and improve outcomes for patients.

Planned target outcomes

We will know we have achieved this if:

- Implementation of an electronic tool for cleaning audits.
- Implementation of an electronic tool for health and safety audits.
- Identification of system for recording patient observations and improving compliance with the care of the deteriorating patient.
- Identifying other opportunities for information technology to release time to care and improve some outcomes for patients.

Monitoring arrangements

The Patient Safety Subcommittee will track the progress of this priority and will report into the Quality Committee.

Accountable Officer

Director of Finance Estates & Information Management and Technology (IM&T)/Deputy Chief Executive and the Director of Nursing, Midwifery, AHPs and Out of Hospital Services.

PRIORITY TWO

Clinical effectiveness: right person, right place, right time

Goal

Our goal is to ensure that all of our patients are located in the most appropriate place from admission to discharge. The patient, upon entering our care, will be cared for in the correct clinical location at the earliest opportunity.

Why?

There is recognised evidence that patients treated as outliers in speciality wards not related to their presentation have poorer outcomes and increased lengths of stay. There is a relationship between being in the incorrect clinical location and receiving poorer quality of care, a weaker safety profile and a negative experience. It has equally been associated with an increased length of stay, organisational inefficiency and worsened organisational financial state. With the range of services we provide, the right place for care can often be the patient's home and our systems must support this.

Who?

This will be a shared priority between the Director of Acute Services, Director of Mental Health and Learning Disabilities, Director of Integrated Urgent and Emergency Care and Director of Nursing, Midwifery, AHPs and Community Services to ensure it supports the patient safety agenda.

How?

We will:

- Treat people in their homes wherever possible.
- Continue to transform community mental health services.
- Ensure robust discharge plans are in place for every inpatient.

- Ensure patients have accurate estimated date of discharge.
- Ensure that patients are assessed and referred to the most appropriate place for treatment, at the earliest opportunity, in all of our care settings.
- Further develop weekend working to improve discharge at weekends.
- Improve emergency planning to ensure that peak pressure times can be managed well (winter, summer and bank holidays).
- Work with partners to reduce Delayed Transfers of Care (moves into residential/nursing care, home support, hospice etc.).
- Support people in leaving the hospital setting at the earliest opportunity, using the community services teams.
- Improve communication for handover and transfers of care.
- Introduce real time monitoring for incorrect placements with ward displays.
- Review frailty model for all elements of our services.

Planned target outcomes

We will know we have achieved this if:

- Increase in risk assessments for patients on CPA.
- Increase in 'see and treat' and 'hear and treat'.
- Bed occupancy of <90%.
- <10% of inpatients 'super stranded'.
- <20% of inpatients 'stranded'.
- Reduction in readmission rates.
- Reduction in out of hours transfers.
- Reduction of delayed discharges and transfers of care.
- Increase in compliance with transfer documentation.
- Reduction in patients moved more than two times (Emergency Department (ED)/Medical Assessment Unit (MAU)/Labour Ward excluded).

Monitoring arrangements

Divisional quality committees.

Accountable Officer

Director of Acute Services, Director of Mental Health and Learning Disabilities, Director of Integrated Urgent and Emergency Care and Director of Nursing, Midwifery, AHPs and Community Services.

PRIORITY THREE

Patient experience: dementia care

Goal

We will support the improvement of care for patients who have dementia in order to improve their quality of life and support the development of a dementia friendly Island.

Why?

The Isle of Wight has a higher than average elderly population and people suffering from dementia is on the rise. We want to be recognised as a Dementia Friendly Division and ensure our patients with dementia have the best experience possible. Dementia is prevalent in the Trust's patient population; helping those with dementia is integral to their care.

Who?

The Director of Nursing, Midwifery, AHPs and Community Services leads on dementia care for the Trust to ensure it supports the Patient Safety agenda.

How?

We will:

- Develop a Trust Dementia Strategy and implement an associated improvement plan.
- We will provide training and continue to develop a highly skilled, dementia aware workforce, who provide compassionate care and are confident in their roles.
- Diagnosing dementia and delirium promptly and providing the right support at the right time.
- Continue to develop dementia friendly areas with secure, safe, comfortable, social and therapeutic environments that facilitate all types of functioning.
- Champion improvements in dementia care at all levels within the organisation.
- Work in collaboration with partner organisations and involve, support and engage carers as partners in care, where appropriate.
- Participate in audits to maintain and improve standards.
- Use the Trust level data developed to monitor, support and improve dementia screening rates.

Planned target outcomes

We will know we have achieved this if:

- Increase in positive responses to surveys and audits.
- Reduction in formal complaints relating to dementia care.
- Improvements in PLACE scores relating to dementia-friendly environments.
- Increase in staff trained Dementia Care.

Monitoring arrangements

Divisional Quality Committees, Patient Experience Subcommittee & Quality Committee.

Accountable Officer

Director of Nursing, Midwifery, AHPs and Community Services.

Assurance Statements

Review of Services

During 2018/19 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 **75** of these NHS Services.

The income generated by the NHS services reviewed in 2018/19 represents **87.89** per cent of the total income generated from the provision of NHS Services by the Isle of Wight NHS Trust for 2018/19.

Participation in Clinical Audits

During 2018/19, 65 national clinical audits, and two 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 96% of national clinical audits and 100% of national confidential enquiries that 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 2018/19 are as follows in the tables below:

National clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19	
No.	**Peri- and Neonatal**
1.	Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
2.	Perinatal mortality surveillance (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
3.	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
4.	Perinatal mortality and morbidity confidential enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme ((MBRRACE-UK)).
5.	National Neonatal Audit Programme (NNAP).
6.	National Maternity and Perinatal Audit (NMPA).
	Children
7.	National Audit of Seizures and Epilepsies in Children and Young People (RCPCH).
8.	Diabetes (Paediatric) (NPDA).
9.	Feverish Children (Care in Emergency Departments, RCEM).
	Acute care
10.	Vital Signs in Adults (Care in Emergency Departments, RCEM).
11.	VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments, RCEM).
12.	Case Mix Programme (CMP) (ICNARC).
	Long term conditions
13.	National Diabetes Inpatient Audit (NaDIA).
14.	National Diabetes Foot Care Audit (NDFA).
15.	National Diabetes Audit: National Pregnancy in Diabetes Audit.
16.	Inflammatory Bowel Disease (IBD) programme/IBD Registry.
17.	Secondary care work stream (National Asthma and COPD Audit Programme (COPD) Audit Programme).
18.	Pulmonary rehabilitation work stream (National Asthma and COPD Audit Programme (COPD) Audit Programme).
19.	Asthma in adults secondary care work stream National Asthma and COPD Audit Programme (BTS).
20.	Non-invasive ventilation – Adults (BTS).

What is Clinical Audit?

Clinical Audit is a quality improvement process that seeks to improve patient care. Elements of care are selected and evaluated against a specific set of criteria. Where required, changes are made to improve care.

National clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19	
21.	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) (BSR).
	Elective procedures
22.	Elective surgery (National PROMs Programme).
23.	Female Stress Urinary Incontinence Audit (BAUS Urology Audits).
24.	Adult Cataract surgery (National Ophthalmology Audit).
25.	Getting It Right First Time – Surgical Site Infection Audit.
	Cardiovascular disease
26.	Cardiac Rhythm Management (CRM) (NICOR).
27.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) (NICOR).
28.	National Congenital Heart Disease (CHD) (NICOR).
29.	National Heart Failure Audit (NICOR).
30.	National Cardiac Arrest Audit (NCAA).
31.	Cardiac Rehab (NICOR).
32.	Sentinel Stroke National Audit programme (SSNAP).
	Cancer
33.	Bowel cancer (NBOCAP).
34.	National Audit of Breast Cancer in Older People (NABCOP).
35.	Lung cancer (NLCA).
36.	National Prostate Cancer Audit.
37.	Oesophago-gastric cancer (NAOGC).
	Trauma
38.	Knee replacement (National Joint Registry (NJR)).
39.	Hip replacement (National Joint Registry (NJR)).
40.	Major Trauma: The Trauma Audit & Research Network (TARN).
41.	National Emergency Laparotomy Audit (NELA).
42.	National Hip Fracture Database (Falls and Fragility Fractures Audit Programme (FFFAP)).
43.	National Inpatient Falls Audit (Falls and Fragility Fractures Audit Programme (FFFAP)).
	Blood services
44.	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme.
45.	Serious Adverse Blood Reactions and Events (SABRE).
46.	Reducing the impact of serious infections – Antibiotic Consumption (Antimicrobial Resistance and Sepsis)* (Public Health).
47.	Reducing the impact of serious infections – Antimicrobial Stewardship (Antimicrobial Resistance and Sepsis).
48.	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection (Public Health).

National clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018 / 19	
	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study
49.	Pulmonary Embolism.
50.	Acute Bowel Obstruction.
	Maternity
51.	National Pregnancy in Diabetes Audit (NPDA).
52.	Confidential enquiry into serious maternal morbidity (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
53.	Maternal mortality surveillance (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
54.	Perinatal Mortality Surveillance (reports annually) (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
55.	Perinatal Mortality and Morbidity confidential enquiries (reports every second year) (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).
	Mental Health
56.	Learning Disability Mortality Review Programme (LeDeR).
57.	Suicide, Homicide & Sudden Unexplained Death (Mental Health Clinical Outcome Review Programme (NCISH)).
58.	Safer Care for Patients with Personality Disorder (Mental Health Clinical Outcome Review Programme (NCISH)).
59.	The Assessment of Risk and Safety in Mental Health Services (Mental Health Clinical Outcome Review Programme (NCISH)).
60.	Suicide by children and young people in England(CYP) (Mental Health Clinical Outcome Review Programme (NCISH)).
61.	National Audit of Psychosis (NCAP) Core and spotlight audits.
62.	National Audit of Anxiety and Depression (RCPSYCH).
63.	National Audit of Dementia (RCPSYCH).
64.	POMH – UK four work streams (Clozapine, Lithium, Anti-depressants and depot antipsychotics).
	Trustwide
65.	National Audit of Care at the End of Life (NACEL) (NHS Benchmarking Network).
66.	National Mortality Case Record Review Programme (RCP).
67.	Seven Day Hospital Services (The 7DS survey takes place biannually, once in the Spring and once in the Autumn) (NHS England).

The national clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in, and for which data collection was completed during 2018/19 are listed below, 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.

National clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in 2018/19	Participation	% Cases submitted
Peri- and Neonatal		
Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Perinatal mortality surveillance (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Perinatal mortality and morbidity confidential enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme ((MBRRACE-UK)).	Yes	Data collection still ongoing
National Neonatal Audit Programme (NNAP).	Yes	Data collection still ongoing
National Maternity and Perinatal Audit (NMPA).	Yes	Data collection still ongoing
Children		
National Audit of Seizures and Epilepsies in Children and Young People (RCPCH).	Yes	Data collection still ongoing
Diabetes (Paediatric) (NPDA).	Yes	Data collection still ongoing
Feverish Children (Care in Emergency Departments, RCEM).	Yes	100%
Acute care		
Vital Signs in Adults (Care in Emergency Departments, RCEM).	Yes	100%
VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments, RCEM).	Yes	Data collection still ongoing
Case Mix Programme (CMP) (ICNARC).	Yes	Data collection still ongoing
Long term conditions		
National Diabetes Inpatient Audit (NaDIA).	Yes	100%
National Diabetes Foot Care Audit (NDFA).	Yes	100%
National Diabetes Audit: National Pregnancy in Diabetes Audit.	Yes	100%
Inflammatory Bowel Disease (IBD) programme/IBD Registry.	Yes	100%
Secondary care workstream (National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme).	Yes	100%
Pulmonary rehabilitation workstream (National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme).	Yes	Data collection still ongoing
Asthma in adults secondary care workstream National Asthma and COPD Audit Programme (BTS).	Yes	100%
Non-invasive ventilation – Adults (BTS).	Yes	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) (BSR).	Yes	100%

National clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in 2018/19	Participation	% Cases submitted
Elective procedures		
Elective surgery (National PROMs Programme).	Yes	Data collection still ongoing
Female Stress Urinary Incontinence Audit (BAUS Urology Audits).	Yes	Data collection still ongoing
Adult Cataract surgery (National Ophthalmology Audit).	Yes	Data collection still ongoing
Getting It Right First Time – Surgical Site Infection Audit.	Yes	Data collection still ongoing
Cardiovascular disease		
Cardiac Rhythm Management (CRM) (NICOR).	Yes	Data collection still ongoing
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) (NICOR).	Yes	Data collection still ongoing
National Congenital Heart Disease (CHD) (NICOR).	Yes	Data collection still ongoing
National Heart Failure Audit (NICOR).	Yes	Data collection still ongoing
National Cardiac Arrest Audit (NCAA).	Yes	Data collection still ongoing
Cardiac Rehab (NICOR).	Yes	Data collection still ongoing
Sentinel Stroke National Audit programme (SSNAP).	Yes	Data collection still ongoing
Cancer		
Bowel cancer (NBOCAP).	Yes	Data collection still ongoing
National Audit of Breast Cancer in Older People (NABCOP).	Yes	Data collection still ongoing
Lung cancer (NLCA).	Yes	Data collection still ongoing
National Prostate Cancer Audit.	Yes	Data collection still ongoing
Oesophago-gastric cancer (NAOGC).	Yes	Data collection still ongoing
Trauma		
Knee replacement (National Joint Registry (NJR)).	Yes	Data collection still ongoing
Hip replacement (National Joint Registry (NJR)).	Yes	Data collection still ongoing
Major Trauma: The Trauma Audit & Research Network (TARN).	Yes	Data collection still ongoing
National Emergency Laparotomy Audit (NELA).	Yes	Data collection still ongoing
National Hip Fracture Database (Falls and Fragility Fractures Audit Programme (FFFAP)).	Yes	Data collection still ongoing
National Inpatient Falls Audit (Falls and Fragility Fractures Audit Programme (FFFAP)).	Yes	Data collection still ongoing
Blood services		
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme.	Yes	Data collection still ongoing
Serious Adverse Blood Reactions and Events (SABRE).	Yes	Data collection still ongoing
Reducing the impact of serious infections – Antibiotic Consumption (Antimicrobial Resistance and Sepsis)* (Public Health).	Yes	Data collection still ongoing
Reducing the impact of serious infections – Antimicrobial Stewardship (Antimicrobial Resistance and Sepsis).	Yes	Data collection still ongoing
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection (Public Health).	Yes	Data collection still ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Pulmonary Embolism.	Yes	100%
Acute Bowel Obstruction.	Yes	100%

National clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in 2018/19	Participation	% Cases submitted
Maternity		
National Pregnancy in Diabetes Audit (NPDA).	Yes	Data collection still ongoing
Confidential enquiry into serious maternal morbidity (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Maternal mortality surveillance (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Perinatal Mortality Surveillance (reports annually) (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Perinatal Mortality and Morbidity confidential enquiries (reports every second year) (Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)).	Yes	Data collection still ongoing
Mental Health		
Learning Disability Mortality Review Programme (LeDeR).	Yes	Data collection still ongoing
Suicide, Homicide & Sudden Unexplained Death (Mental Health Clinical Outcome Review Programme).	Yes	Data collection still ongoing
Safer Care for Patients with Personality Disorder (Mental Health Clinical Outcome Review Programme (NCISH)).	Yes	Data collection still ongoing
The Assessment of Risk and Safety in Mental Health Services (Mental Health Clinical Outcome Review Programme (NCISH)).	Yes	Data collection still ongoing
Suicide by children and young people in England(CYP) (Mental Health Clinical Outcome Review Programme (NCISH)).	Yes	Data collection still ongoing
National Audit of Psychosis (NCAP) Core and spotlight audits.	Yes	100%
National Audit of Anxiety and Depression (RCPSYCH).	Yes	100%
National Audit of Dementia (RCPSYCH).	Yes	100%
POMH – UK four work streams (Clozapine, Lithium, Anti-depressants and depot antipsychotics).	Yes	100% ongoing annual audit
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions.		

The Trust did not participate in the following national audits during 2018/19:

Audit	Participation	% Cases submitted
National Heart Failure Audit (NICOR).	No	0% – No capacity (require in-patient heart failure nurse specialist).
BTS Pulmonary Hypertension.	No	0% – Only applies to eight regional centres.
Cancer in Children and Young People (NCEPOD).	No	0% – No patients eligible for study.
Long term ventilation in children and young people (NCEPOD).	No	0% – No patients eligible for study.
National Comparative audit of blood transfusion – management of massive haemorrhage.	No	0% – Patient numbers too low to participate.
Adult Cardiac Surgery.	No	0% – No cardiac surgery perform by Trust.
BAUS Urology Audit – Cystectomy.	No	0% – Service not provided by Trust.

Audit	Participation	% Cases submitted
BAUS Urology Audit – Nephrectomy.	No	0% – Service not provided by Trust.
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL).	No	0% – Service not provided by Trust.
BAUS Urology Audit – Radical Prostatectomy.	No	0% – Service not provided by Trust.
Child Health Clinical Outcome Review Programme (NCEPOD – Long tern ventilation in Children and Young People).	No	0% – Excluded by NCEPOD as no patients meet criteria.
National Audit of Intermediate Care.	No	0% – Service not provided by Trust.
National Audit of Percutaneous Coronary interventions (PCI).	No	0% – Service not provided by Trust.
National Bariatric Surgery (NBSR).	No	0% – Service not provided by Trust.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major injury (NCASRI).	No	0% – Service not provided by Trust.
National Vascular Registry.	No	0% – Service not provided by Trust.
Neurosurgical National Audit Programme.	No	0% – Service not provided by Trust.
Paediatric Intensive Care (PICANet).	No	0% – No Paediatric intensive care unit at the Trust.
UK Cystic Fibrosis Registry.	No	0% – Service not provided by Trust.

The reports of four national clinical audits were reviewed by the provider in 2017/18 and Isle of Wight NHS Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit	
Recommendation	**Actions required** *(specify "None", if none required)*
National Maternity and Perinatal Audit (NMPA).	No action required.
National Paediatric Pneumonia Audit.	No action required.
Sentinel Stroke National Audit programme (SSNAP).	Comprehensive action plan being developed and monitored by the Medicine Care Group.
National Audit of Diabetes inpatient 2017 (NADIA).	Hospital foot Risk assessment tool – Develop the use of the assessment tool.
National Hip Fracture Database – Falls and Fragility Fractures Audit Programme (FFFAP).	Ongoing action plan – this audit is reported annually one year after completion, however the Trust reports on current data to the CCG and has an ongoing action plan.
National Emergency Laparotomy Audit (NELA).	Although in the latest report the Trust is performing better in a number of areas, an action plan is currently being developed to drive further improvement.
National Audit of Lung Cancer.	No action required. The Trust performs very well on this audit.
Royal College of Emergency Medicine (three audits): • Pain in Children • Procedural Sedation • Fractured Neck of Femur	It has been found that the Royal College of Emergency Medicine audit system is not able to accept the paper records currently used in the Emergency Department and therefore our actual performance is not reflected in the audit report. Local audit of the RCEM subjects have been planned to demonstrate the Trusts actual performance on the measures used by RCEM.
Colposcopy (KC65).	No action required.
National Joint Registry (NJR)	No action required.

National Audit of Oesophago-gastric cancer (NAOGC).	No action required.
National Confidential Inquiry Into Suicide And Homicide (NCISH)	No action required.
National Bowel Cancer Audit (NABCOP).	No action required.
Oesophago-gastric cancer (NAOGC).	No action required.
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions.	

The reports of 13 local clinical audits were reviewed by the provider in 2018/19 and Isle of Wight NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audit	
Recommendation	**Actions required** *(specify "None", if none required)*
Trauma & orthopaedics antibiotic prophylaxis.	None required – all standards met.
Audit of urine samples on in-patients treated for Urinary Tract Infection (UTI) or sepsis of unknown Source.	1. Improve timely urine culture collection for patients treated for UTI – Revision to admission pathway booklet advised. Poster/newsletter info for ED/MAU to be produced to highlight appropriate urine sampling practice.
Community acquired pneumonia.	1. CURB-65 in clerking proforma; administration of antibiotics within four hours; antibiotics according to hospital guidelines; re-audit in six month time – audit presented in grand round; poster in process for CURB-65 score and antibiotics guideline per Trust protocol.
Alcohol Related Liver Disease Audit (ARLD) audit (Wessex Trust).	None required.
NICE guideline QS95 bipolar in adults.	None required.
Induction of labour.	1. Explanation to patient: reasons, procedure and risks/benefits and information leaflet given should be properly documented – Staff were reminded about proper documentation. Regular checking on documentation by risk management midwife.
Eczema in children.	None required.
Completion of safer surgery checklist for births in theatre.	1. Meeting to take place to discuss recommendations. 2. Develop new version of the checklist. 3. Sign on theatre door to remind staff to complete checklist before leaving theatre. 4. Add safer surgery checklist to pre theatre checklist and raise profile of pre-theatre checklist for all theatre cases. 5. Share findings of this audit on mandatory study days, ward handover, topic of the month and any other meetings. 6. Inform clinical staff of the timings and relevance of their signatures on each part of the checklist. 7. Share background (safety, timing, development) of the checklist. 8. Implement safer surgery guidance to support understanding and use. 9. Discuss with anaesthetists and consultant obstetricians for responsibility decision.

Re-Audit of NOAC (Novel Oral Anticoagulant) Prescription in Patients with Atrial Fibrillation on the Stroke Unit.	1. Insertion of sticker to Stroke booklet on first presentation to Stroke ward: As discussed, the NOAC sticker is a very useful and effective tool in ensuring we adhere to our targets for each and every patient started on a NOAC. To maximise the benefits yielded, we plan for the sticker to be added to the notes as soon as a new patient arrives on the ward. We envisage this being a shared responsibility between the Junior Doctors, Ward Clerk and Ward Pharmacist. This plan was introduced at the Re-audit presentation and will be further actioned in the coming weeks. 2. Maintain good supply of information leaflets: As discussed there were issues with supply of NOAC patient leaflets during the period assessed. By highlighting this as an issue, and because the ward is now able to generate its own leaflets, it is hoped these problems can be avoided in the future. 3. Verbal induction: The stroke induction pack provided to juniors on starting on the stroke ward is a valuable resource when trying to learn the unfamiliar systems. However, it contains a lot of information and details on use of the NOAC sticker is just one of many areas covered. To help expedite juniors achieving the understanding of the way things should be carried out on the ward we plan for the first ward teaching session to be based upon going through the stroke booklet verbally with the new intake. 4. Re-audit in 18 months' time: Re-audit should be carried out to re-assess the effectiveness of the interventions proposed above. This is important, as there is still significant potential for improvement.
Improving the quality of pre-operative care provided by SHOs to patients admitted with fractured Neck of Femur.	1. Present the audit to the orthopaedic department and at medical grand-round to raise awareness of the current issues and need for improving practice. 2. Teaching session to be incorporated into the FY2 core teaching programme to include the peri-operative management of patients admitted with fractured neck of femur, highlighting the standards required for pre-operative patient assessment and prescribing. 3. Practical teaching session by Consultant anaesthetist to be delivered to the junior doctors, FY2s and A&E staff, for performing nerve block. 4. Re-audit following implementation of recommendations.
Assessment of management of periorbital and orbital cellulitis in children (St. Mary's Hospital).	1. Update the internal guidelines (to be discussed with the paediatric, ophthalmology and Ear, Nose and Throat consultants). 2. Set time to give intravenous antibiotics (IV Abx) after diagnosis. 3. Set time for Ophthalmology/ENT review since admission. 4. Add mild/moderate/severe (post-septal) grading, with oral antibiotics for mild cases. 5. Review follow up arrangements (depending on severity). 6. Review essential clinical signs requirements. 7. Give antibiotics not less than ten days (as per "microguide" guidelines).

Communication and acknowledgement of significant radiological results.	1. Highlight critical, urgent, unexpected significant findings on the first line of the radiology report. 2. E-care logic to allow important imaging reports to be highlighted electronically and be marked as 'read' by referrers. 3. Documentation of communication (and modality) between radiology and clinical teams regardless of success. 4. Documentation of actions initiated by clinical teams following significant report findings. 5. Documentation of reports being sent to Oncology Multi-Disciplinary Team and GPs in cancer cases. 6. Discuss audit findings with local IT and radiology department as well as Medica to improve services. 7. Significant reports to be added to discharge summary "report" section automatically.
Blood transfusion in obstetric practice.	1. To file clinical incident reports for all Major Obstetric Haemorrhage (MOH). 2. To provide written information leaflets to patients receiving blood transfusion.
Data source: Clinical Audit Programme and final reports 2018/19.	

NCEPOD – Quality Accounts summary 2018/2019

During 2018/2019 hospitals were eligible to enter data in up to 5 NCEPOD studies. Please find below a summary of those studies in which you participated. If you were exempt from any particular study it will not be listed.

Excluded totals shown below can be added to your included cases should it help improve return rates.

Perioperative Diabetes	Cases Included	Cases Excluded	Clinical Q returned*	Excl. Clinical Q returned*	Case notes returned*	Excl. Case notes returned*	Sites Participating	Org. Q. returned*
Isle of Wight NHS Trust								
Surgical Questionnaire	2	0	2	0	0	0	1	1
Anaesthetic Questionnaire			1	0				

Pulmonary Embolism	Cases Included	Cases Excluded	Clinical Q returned*	Excl. Clinical Q returned*	Case notes returned*	Excl. Case notes returned*	Sites Participating	Org. Q. returned*
Isle of Wight NHS Trust								
Clinical Questionnaire	6	0	6	0	6	0	1	1

(Please note this study is still open and the figures have not been finalised)

*** number of questionnaires/ case notes returned including blank returns with a valid reason, questionnaires marked "not applicable", and case notes missing with a valid reason.**

Acute Bowel Obstruction	Cases Included	Clinical Q returned*	Case notes returned*	Sites Participating	Org. Q. returned*
Isle of Wight NHS Trust					
Clinician Questionnaire	2	2	1	1	1

Please note this study is still open and the figures have not been finalised
Case notes have been limited up to 2 per hospital site.

Long Term Ventilation	Cases Included	Clinical Q requested	Clinical Q returned	Case notes requested	Case notes returned	Sites Participating	Org. Q. returned*
Isle of Wight NHS Trust							
Acute Admission Questionnaire	0	0	0	0	0	0	To be sent out
Lead Adminission Questionnaire	0	0	0	NA	NA		

(Please note this study is still open and the figures have not been finalised)

Community questionnaires and tracheostomy insertion questionnaires are still to be sent out. Patients may have been identified by another organisation as receiving either LTV initiation, ongoing or community care in your organisation.
In this case, your 'Cases Included' figure will have risen as we will have allocated questionnaire(s) for those patient(s) to your organisation but, as we are still in the process of sending out cases, you may not have received the questionnaires yet.
Therefore, the 'Cases Included' figure may be higher than expected.

*** number of questionnaires/ case notes returned including blank returns with a valid reason, questionnaires marked "not applicable", and case notes missing with a valid reason.**

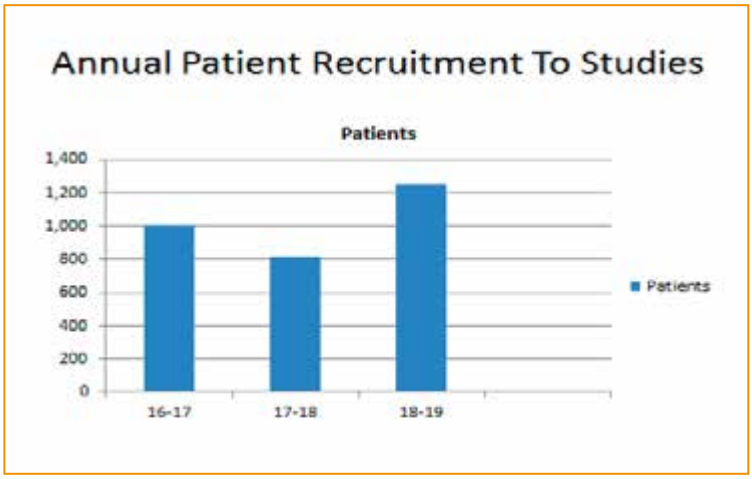
What is Clinical Research?

Clinical Research is a branch of medical science that determines the safety and effectiveness of medication, diagnostics products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.

Participation in Clinical Research

The number of patients receiving relevant NHS health services provided or subcontracted by the Isle of Wight NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee, was 1275 (as at 31st March 2019).

This was a significant increase on the previous year as shown in the table and is testimony to the hard work of staff across the Trust.



Commitment to research as a driver for improving the quality of care and patient experience

Every new drug or improvement in the way we look after our patients and service users is driven by research. Britain has a fantastic history of medical research, for instance winning a total of 34 Nobel Prizes in Medicine, second only in world terms, to the United States of America (USA).

Participation in clinical research is not only important for our patients, it is important for our staff, as through active participation in research, our clinical staff stay abreast of the latest possible treatments, network with other research active centres across the world, and develop skills like data management and disease assessment which have wider benefits for our Trust.

During 2018/2019, 23 studies were granted research governance approval by the Trust with a further 31 studies remaining open from previous years. These covered the following clinical specialties; asthma & allergy, cancer, cardiovascular disease, children, dementia & degenerative diseases, diabetes, gastroenterology, orthopaedics, mental health, metabolic & endocrine disease, ear nose and throat, ophthalmology, reproductive health & childbirth, respiratory disorders, stroke and health service management. This work was supported by an allocation of £384,100, from the regional Clinical Research Network, which covers clinician sessions, research nurses and associated staff, NHS service support (pathology, radiology and pharmacy) and research set-up and management; in total – 21 staff members.

The David Hide Asthma and Allergy Research Centre (DHAARC), remains the most important site for research at the Isle of Wight NHS Trust, typically recruiting more than half the total number of patients recruited at the Trust. The Centre, in collaboration with the University of Southampton, undertakes studies in the field of paediatric and adult asthma and allergy research and has an international reputation for this type of research. DHAARC studies are carried out with other Universities in the UK and around the world; including The Jolla, California, Michigan State University, University of Memphis, The University of Manchester, University of Bristol, Imperial College London, University of Oslo, University of Portsmouth, University of Colorado Denver School of Medicine | Children's Hospital Colorado

During 2018/19, ten incident reports were filed for patients taking part in studies. Any patients taking part in an interventional study, such as taking a medication, are automatically reported via the Trust incident reporting scheme, if they develop anything which requires treatment or investigation; this will include things which ultimately can be shown to be not due to the investigational medication. One patient taking a study medication required admission for treating an infection which was likely due to the study medication; they made a full recovery but were withdrawn from the study. This was the only patient we believe who developed a problem through taking part in research.

For 2019/20 we are recruiting a new manager to allow us to work more closely together, build on current strengths and develop new opportunities on the Island and with local mainland partners. We hope to expand our commercial research and stimulate new areas to come on board with research, to ensure a stable and viable growth in Trust R&D activity. Our activity is reported to the Clinical Effectiveness Committee throughout the year.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

The Commissioning for Quality and Innovation (CQUIN) Payment Framework aims to support the cultural shift towards making quality the organising principle of NHS services. In particular, it aims to ensure that local quality improvement priorities are discussed and agreed at board level within, and between, organisations. The CQUIN Payment Framework is intended to embed quality at the heart of commissioner provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation.

Goals agreed with our commissioners

A proportion of Isle of Wight NHS Trust's income in 2018/19 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 payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request from https://www.england.nhs.uk/publication/commissioning-for-quality-and-innovation-cquin-guidance-for-2017-2019/

What are CQUINs?

CQUIN stands for Commissioning for Quality and Innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.

CQUINS 2018/19 report

 Achieved

 Not achieved

 Improvements evidenced

National / Local	CQUIN no.	CQUIN Indicator	Definition / Requirement	Key
National	1a	**Improving health and wellbeing of NHS staff**	• Extended service for rapid access to Physiotherapy for staff. • Regular mindfulness sessions continue in Occupational Health and are also provided for teams in their own workplace. • Implementing NICE workplace guidance – Supporting line managers through training sessions such as "Promoting Health and Wellbeing in your team." • Rapid access to Mental Health Practitioners for stress and other work related mental health conditions.	
	1b	**Healthy food for NHS staff, visitors and patients**	• The Trust has ensured that there are no price promotions or advertisements of sugary drinks and foods high in fat, sugar or salt. These foods have also been banned at checkouts. • Healthy options are available for staff working night shifts. 80% of confectionery and sweets on sale do not exceed 250kcal and 75% of pre-packed sandwiches or ready meals do not exceed 400kcal.	
	1c	**Improving the uptake of flu vaccinations for front line staff within providers**	The majority of front line staff have received flu vaccinations, however the target of 75% was not achieved. Progress in achievement of the CQUIN is ongoing and work is already underway to meet the CQUIN target during 2019 – 2020.	

National	2a	**Timely identification of sepsis in emergency departments and acute inpatient settings**	All of the Trust's milestones were met this means that more patients are being screened for Sepsis in a timely manner and being provided with the right treatment, at the right time, whether inpatient or in the emergency department.	
	2b	**Timely treatment of sepsis in emergency departments and acute inpatient settings**		
	2c	**Antibiotic review – Assessment of clinical antibiotic review between 24 – 72 hours of patients with sepsis who are still inpatients at 72 hours**	Q3 milestones met and targets exceeded. Data submission completed by CEL.	
	2d	**Reduction in antibiotic consumption per 1,000 admissions**	• Compared with the national average our figures are better across the board reflecting our historic performance with regards to antibiotic consumption and continued antimicrobial stewardship performance. • The Trust Antimicrobial guidelines have been updated and launched on the Intranet. • Percentage Access vs Aware category antibiotics is on target to achieve >55% (currently 61% year to date). • Total antibiotic consumption – will not achieve the required 2% reduction against 2016 baseline. Carbapenem usage – will not achieve the required 2% reduction against 2016 baseline.	
National	3a	**Cardio-metabolic assessment and treatment for patients with psychoses**	• Awaiting national audit results.	
	3b	**Collaboration with Primary Care Clinicians**	• Shared Protocol being developed to improve collaboration. • Results of the local audit on the content of 'patient discharge' summaries awaited.	
National	4	**Improving services for people with mental health needs who present at A&E**	Improved service for regular attenders with mental health problems with re-direction to appropriate services.	
National	5	**Transitions out of Children and Young People's Mental Health Services (CYPMHS)**	Questionnaires sent to pre and post – transition clients to improve the transition process.	

National	6	**Offering Advice and Guidance (A&G)**	• All services are supplying advice and guidance through the required portal. • The majority of advice and guidance requests from Primary Care are being responded to within 72 hrs.	
National	7	**NHS e-Referrals**	A one year CQUIN running 2017/18 only.	
National	8c	**Supporting Proactive and Safe Discharge – Care Homes**	• Improvement being made to discharge process and numbers discharged before lunch have increased whilst length of bed days has decreased. • Close working with discharges to Care Homes and protocols established.	
National	9a–c	**Tobacco screening, brief advice and referral and medication offer**	• All nurses trained on alcohol and tobacco screening. • All nurses trained on provision of brief advice. Improved paperwork to capture data in use.	
National	9d–e	**Alcohol screening, brief advice or referral**		
National	10	**Improving the assessment of wounds**	• Clinical Audit is identifying continuous improvement on the undertaking of wound assessments so that effective treatment based on the outcome of the assessment can be provided.	
National	11	**Personalised care and support planning**	District Nurses have been trained to assist patients in undertaking personalised care and support planning.	
National	12	**A reduction in the proportion of ambulance 999 calls that result in transportation to a type one or type two A&E department**	Potentially a proportion of calls are referred back to an Advanced Nurse Practitioner for appropriate profiling. Cases from these calls that do not need to be conveyed, can all be counted.	
National	13	**Increasing the proportion of NHS 111 referrals to services other than to the ambulance service or A&E department**	Green calls and Emergency Department dispositions are being re-triaged by an Advanced Clinician.	

What is the Care Quality Commission (CQC)?

The CQC is an independent regulator of all health care in England. Their job is to make sure that all organisations providing health care meet recognised government standards. They have the power to visit organisations and view the services and care they provide, make recommendations to improve standards and issue enforcement notices where required.

What Others Say about the Isle of Wight NHS Trust

Registration with the Care Quality Commission and periodic/special reviews

Statements from the CQC

The Isle of Wight NHS Trust is required to register with the Care Quality Commission and its current registration status is **registered with conditions**. Isle of Wight NHS Trust has the following conditions on registration:

- Section 31 in relation to Community Mental Health Services.

These conditions involve a fortnightly data return to the Care Quality Commission against agreed information requirements.

Special Reviews/Investigations/Planned Reviews

The Isle of Wight NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19. [This was in relation to Urgent and Emergency Care].

The Care Quality Commission has taken enforcement action against Isle of Wight NHS Trust during 2018/19. This is in the form of a warning notice, Section 29A, in relation to Urgent and Emergency Care.

The reasons for the Care Quality Commission's view that the quality of health care, provided on the 21st January 2018 during a one day inspection, required significant improvement are as follows:

1. Patients were cared for and treated in non-designated areas for clinical care in the emergency and accident department, which increased the risk of them not having the appropriate assessments, care and treatment.
2. Patients were not always assessed in a timely or safe manner, or assessed by staff who were suitably qualified.
3. There were insufficient numbers of staff on duty to deliver safe care and treatment to patients.

The Isle of Wight NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC, as detailed in the table on following page. The actions are monitored on a weekly basis through the Acute, Urgent and Emergency Care Transformation Programme of work.

Must Do Actions	Progress on Actions	Outcome RAG rating
Patients must be treated in designated areas of the department in order to maintain privacy, dignity & respect. Appropriate care and treatment must be given to all patients; they must be triaged appropriately and appropriate clinical settings sought.	Organisational Escalation Policy updated and in place. Adherence to this policy will ensure that patients are cared for in the most appropriate setting and not within non-designated cubicles. Robust Safety Round process now implemented, resulting in senior staff undertaking two-hourly reviews of patients within the department to ensure care plans are in place and being adhered to.	**Achieved in full**
"Triage is a face-to-face contact with the patient" and that it should be carried out by a qualified healthcare professional who has had specific training.	All patients are assessed by either the streaming nurse, triage nurse or by the initial assessment team. This always includes a registered nurse and a senior doctor. Triage training and competencies for staff new to role is available.	**Achieved in full**
Detailed handovers need to be provided to staff within the rapid assessment and treatment area.	Medical and nursing staff are allocated to ensure detailed handovers take place throughout the day. Handover standard operating procedure in place.	**Achieved in full**
Patient assessments must be completed by registered healthcare professionals experienced in emergency/urgent care who have received specific training and can demonstrate developed interpersonal skills.	Review of handover process from ambulance crews to nursing staff identified that the nurse designed to care for the patient was not always the person looking after the patient. Every ambulance patient is now handed over to the nurse who will be delivering the initial care to the patient. Senior doctor now designated to undertake initial assessment of patients with nursing staff at peak times.	**Achieved & sustained**
Triage must be completed within 15 minutes from arrival; whether this be by ambulance or otherwise.	Triage nurse allocated for walk-in patients, registered nurse designated for initial assessment, streaming in place to allocate patients to the appropriate onwards area.	**Achieved in full**
Hourly safety checks on patients in the major treatment area must be completed hourly.	Hourly safety check documentation in place, two hourly safety walk-rounds to monitor compliance. Documented.	**Achieved in full**
Safety rounds must include appropriate members of staff in order to review the plan for each patient in the resuscitation room, major treatment area and corridor to ensure that observations are up-to-date and to address any delays in the patient's progress.	Safety rounds completed by nurse in charge with escalation to emergency physician in charge as required and clearly documented and monitored.	**Achieved in full**
Safety rounds must be conducted overnight in order to ensure consistent review of patients care.	Safety rounds completed by nurse in charge with escalation to emergency physician in charge as required.	**Achieved in full**
Patients must be reviewed by specialist doctors/physicians in a timely manner.	Live monitoring available through Qlikview framework. Department inter-professional standards protocol in place for escalation in the event that a specialist doctor does not review in a timely manner. Emergency physician in charge. Doctor present in the initial assessment 12 – 8.	**Achieved in full**

Nurse staffing numbers must meet the Trust's planned staffing requirements – there needs to be enough qualified nurses to run the department.	Recruited to six out of seven Band 7s. Recruited to Band 6 – supernumerary skills/competency and skills assessment for triage. Training Emergency Nurse Practitioners (ENPs), ENP posts being job matched. Recruiting to Advanced Nurse Practitioner posts for minor injuries. Overseas nurse recruits expected over the summer. Nine new EDA posts recruited. Consistently meeting safe staffing levels with clear escalation and use of long line agency staff where required.	**Achieved in full**
The nurse in charge needs to fulfil their role – not be supporting various other duties across the department.	Audit of safety rounds completed, sepsis audit showing increased compliance, suboptimal Emergency Department nurse staffing monitored through Front Door Delivery group.	**Achieved in full**
The nurse in charge needs to maintain consistent oversight of the movement of patients within the department.	Audit of safety rounds completed, sepsis audit showing increased compliance, suboptimal Emergency Department nurse staffing monitored through Front Door Delivery group.	**Achieved in full**
There needs to be enough staff available to identify when a patient is missing in a safe and timely manner.	The Emergency Department have access to security who are available to monitor patients at risk of wandering. Missing Patient policy and CCTV available in the department. Consistently meeting safe staffing levels with clear escalation and use of long line agency staff where required.	**Achieved in full**
We must ensure that patients are not left unattended as this puts them at risk of a deterioration in their conditions not being identified and at risk of injury while climbing off trolleys.	Staff are allocated to treatment areas to ensure patients are monitored at all times. Hourly safety checks and two-hourly safety rounds in place. Volunteers are available in the department to give patients fluids and diet and support patients who are vulnerable.	**Achieved in full**
The role of "Streaming Nurse" needs to be fulfilled on a daily basis in order to ensure patients are directed to the appropriate departments/services.	Streaming nurse in place to ensure patients are directed to the appropriate department/services. Staff training in streaming is available for staff to access. Streaming Standard Operating Procedure is in place for staff to follow.	**Achieved in full**

Key	
	In place
	Achieved in full
	Not met

Advisory requirement

The Trust's current CQC ratings grid for the outcome of the CQC inspection undertaken in January 2018 and the report published on 6th June 2018 is detailed in the table below:

Ratings for the whole Trust

The rating for well-led is based on our inspection at Trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Next CQC Inspection

The Isle of Wight NHS Trust is anticipating a CQC re-inspection to take place during May/June 2019 which will focus on the care provided at the hospital.

As a Trust, we are confident that we have delivered improvements to the service and care we provide over the past year.

The CQC will publish a final report and this will be available on the Trust's website and on the CQC website for the public to access. A copy of the final CQC report will be available at www.cqc.org.uk

Data Quality

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

The Isle of Wight NHS Trust will be taking the following actions to improve data quality:

A vital pre-requisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. The organisation requires high quality data to support a number of business objectives, including safe and effective delivery of care, and the ability to accurately demonstrate the achievement of key performance indicators.

The Trust Data Quality Policy sets out the specific roles and responsibilities of staff and management in ensuring that data is managed effectively from the point of collection, through its lifecycle, until disposal.

In order to monitor adherence to the Data Quality Policy the Isle of Wight NHS Trust will, as a matter of routine, monitor performance in collecting and processing data according to nationally and locally defined standards, and provide appropriate feedback to staff.

Where outcomes are unsatisfactory, root causes will be reviewed and performance management measures implemented at division, team or individual level, as required to deliver a level of performance which supports the Trust's duty of care to service users, as well as statutory performance and financial targets.

Action plans for all areas identified as a concern will be developed and delivery will be overseen by the Information Steering Group.

In addition, a data quality report is provided on a quarterly basis to the performance Committee and a subset of this report is also included within the Trust Board Performance report.

Data quality is included regularly on the internal audit programme and has been assessed by external audit.

ii) NHS Number and General Medical Practice Code validity

The Isle of Wight NHS Trust submitted records during 2018/19 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:

99.4% for admitted patient care;
99.7% for outpatient care; and
98.4% 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.

The Isle of Wight NHS Trust has taken the following actions during 2018/19 to improve data quality. These actions will also be undertaken during 2019/20 to further improve data quality:

iii) Information Governance Toolkit attainment levels

The Data Quality and Records Management attainment levels assessed within the Data Security and Protection Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

The Isle of Wight NHS Trust's Information Governance Assessment (IGA) (Data Security and Protection Toolkit) overall score for 2018/19 was **'Standards not fully met'**.

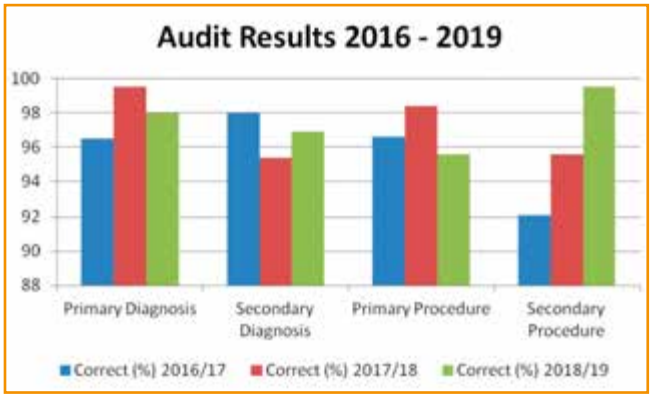
The Trust submitted its first Data Security Protection Toolkit (DSPT) return at the end of March 2019. The DSPT has replaced the previous Information Governance Toolkit (IGT) and has a different scoring system from previously. The Trust is now being measured through evidence required across 40 separate assertions. The Trust met 37 of these assertions and submitted an improvement plan which has been agreed with NHS Digital to address the remaining three assertions by the end of June 2019. The improvement plan is now in the process of being implemented.

iv) Clinical Coding Error Rate

The Isle of Wight NHS Trust was subject to the Information Governance 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:

	Correct (%) 2018/19
Primary Diagnosis	2.0
Secondary Diagnosis	3.1
Primary Procedures	4.4
Secondary Procedures	0.5

These results are comparable with previous years as shown in the graph below:



1) Learning from deaths

During the reporting period April 2018 to March 2019, 559 of the Isle of Wight NHS Trust's patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

Quarter	Number
Quarter One	142
Quarter Two	112
Quarter Three	137
Quarter Four	168

By 31st March 2019, 89 (15.9%), case record reviews and six investigations have been carried out in relation to 559 of the deaths included above.

In six cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Quarter	Number
Quarter One	32
Quarter Two	21
Quarter Three	14
Quarter Four	17

Six (1%) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter as shown in the table below, this consisted of:

- Four representing 2.8% of the number of deaths which occurred in the quarter for the first quarter.
- One representing 0.8% of the number of deaths which occurred in the quarter for the second quarter.
- One representing 0.72% of the number of deaths which occurred in the quarter for the third quarter.
- Zero representing 0% of the number of deaths which occurred in the quarter for the fourth quarter.

Quarter One	4	2.8%
Quarter Two	1	0.8%
Quarter Three	1	0.72%
Quarter Four	0	0%

These numbers have been estimated using the Learning from Deaths Framework and the Serious Incident Framework.

All acute inpatient deaths at Isle of Wight NHS Trust are reviewed in some way. The majority of these (93%) undergo mortality screening and case note review as per the Learning from Deaths guidance. At screening a numbered outcome is identified:

1 – No care concerns – no action taken.

2 – Concerns regarding care but **not** contributing to death – immediate quick action to be taken from mortality review meeting, see below.

3 – Further review of case notes using the Structured Judgement Review (SJR) methodology is required to establish if changes in care could have altered outcome.

4 – Significant concerns after initial screening – Datix incident form completed and case to be reviewed as part of the Incident Review Process, to determine if a Serious Incident Investigation needs to be undertaken.

Those patients who are not able to be screened are more likely than not to already be part of another review process, such as Cardiac Arrest.

Those patient deaths where a more detailed case note review is required are subjected to a Structured Judgement Review which is undertaken by an appropriately trained and experienced senior clinician who has had no direct involvement in the patient's care. During the reporting period 89 Structured Judgement Reviews were undertaken. Learnings have identified a number of recurrent themes and these follow similar patterns identified in Serious Incidents and incident reviews, namely:

- Theme one – **Could the patient have been recognised as nearing the end of their life earlier thus ensuring more timely access to 'end of life' services and care.**
  - Early recognition that patients are approaching the end of their life is of paramount importance to the Trust and is a challenge locally and nationally. Work continues to improve this for our patients and their families and friends.
  - Effort has been made to support staff in having often difficult and challenging conversations when the future is uncertain. During 2018/19 it was recognised that there was crossover between the End of Life Team (Hospital) and the Palliative Care Team (Hospice) Led by the newly appointed Clinical Director for End of Life Care, working together with the Mountbatten Hospice, a new integrated team was operationalised. This team now known as the Integrated Palliative and End of Life Care Team (IPET), will cover the hospital and is already noted to have improved patients and families experience.
- Theme two – **Could/should a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) have been completed earlier?**
  - Following a number of issues relating to the DNACPR process and completion of the documentation, a cluster review was undertaken and work focussed on the learning from these episodes.
  - Work was undertaken across the Trust in respect of this and towards the latter part of the year the mortality screeners and SJR reviewers have noted that early decision making has improved and that the forms are being reviewed and signed in a more timely manner.
  - In the last quarter of the reporting period there were no incidents of patients being resuscitated as a consequence of the DNACPR form not being completed correctly.

- Theme three – **Earlier recognition of deterioration in patients and subsequent escalation.**
    - The Trust has undertaken significant work in improving the early recognition of deteriorating patients.
    - The National Early Warning Score (NEWS2) is now fully implemented.
    - Focus around the management of acute kidney injury and reducing the impact of serious infections (antimicrobial resistance and managing sepsis) has continued.

The learning identified from the SJR process at Isle of Wight NHS Trust reflects the national picture, in particular the Royal College of Physicians National Mortality Case Record Review for 2018, with the top five weighted themes being:

- Recognition of end of life.
- Discussion with patient/relatives.
- End of Life care overall.
- Use of palliative care plan.
- DNACPR.

Qualitatively the mortality screening process is starting to see changes such as improved documentation, proactive escalation of concern of deteriorating patients, earlier 'decision making' in respect of DNACPR and End of Life referral in particular. As the emerging themes form, the Trust will report them and appropriate action will be taken.

During the reporting period the Trust has been focusing on embedding the Learning from Deaths Framework and enhancing existing mortality review processes that happen across the Trust. The Trust Mortality Review Group continues to review and summarise the themes coming from the case reviews and that is now being disseminated across the Trust. Work has continued to strengthen the links between the Trust Mortality Review Group and departmental mortality groups, to ensure synergised working between the case review process and the Serious Incident framework.

There are no case record reviews or investigations in this reporting period relating to deaths from the previous reporting period.

Below are the tables that indicate our performance against the quality indicators over the last year.
The key is:

Our Latest Performance	
National Average Performance	
Worst Quartile Performance	
Median Range	
Best Quartile Performance	

2) Reporting against core indicators

		Data from Health & Social Care Information Centre – Indicator Portal						
Ref.	Indicator description	Period	IW NHS Trust performance	National target	National worst	National best	National average	Performance
12 a)	Summary Hospital-level Mortality Indicator (SHMI)	Oct 17 – Sep 18	**1.01**	n/a	1.27	0.69	1.00	
As a result of our current SHMI score the Isle of Wight NHS Trust is placed in SHMI Band 2 which indicates the observed number of deaths within 30 days of discharge from hospital was 'as expected'. The Trust considers that this data is as described for the following reasons: All inpatient activity is now coded from full casenotes rather than discharge summaries. This has considerably improved the data quality of our SHMI score. 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 monitoring tools and other benchmarking data to help identify areas to improve clinical practice and regular reviews by the Executive Medical Director of patients dying in hospital.								
12 b)	The % of patient deaths with palliative care coding	Oct 17 – Sep 18	**30.9**	n/a	14.3	59.5	33.8	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: Palliative care coding is done using the casenotes and assigned for each FCE to which the team attend to see the patient. Z51.5 is only assigned if it is clearly stated that the specialised team came to see the patient. 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 and work with clinicians to ensure the notes are appropriately updated; this allows the clinical coders to more accurately reflect the appropriate clinical codes.								
13	Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay	Q1–4 2018/19	**95.7%**	95.0%	79.1%	100.0%	96.3%	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The organisation is currently exceeding the national target of 95% for 2018/19. 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 seven days of discharge.								
14. a)	Category 1 – Life Threatening – Average Response Time (mins)	M8–11 2018/19	**10**	7	10	6	7	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Isle of Wight NHS Trust went live with a new Computer Aided Dispatch (CAD) system in October 2018 which, this change enabled us to report more accurately against the new Ambulance standards. 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 undertake the actions outlined in our improvement plan.								

		Data from Health & Social Care Information Centre – Indicator Portal						
Ref.	Indicator description	Period	IW NHS Trust performance	National target	National worst	National best	National average	Performance
14. b)	Category 1 – Life Threatening – 90th Percentile Response Time (mins)	M8–11 2018/19	**19**	15	19	11	13	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Isle of Wight NHS Trust went live with a new CAD system in October 2018 which, this change enabled us to report more accurately against the new Ambulance standards. 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 undertake the actions outlined in our improvement plan.								
14. c)	Category 2 – Emergency – Average Response Time (mins)	M8–11 2018/19	**21**	18	30	13	24	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Isle of Wight NHS Trust went live with a new CAD system in October 2018; this change enabled us to report more accurately against the new Ambulance standards. 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 undertake the actions outlined in our improvement plan.								
14. d)	Category 2 – Emergency – 90th Percentile Response Time (mins)	M8–11 2018/19	**45**	40	65	23	49	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Isle of Wight NHS Trust went live with a new CAD system in October 2018; this change enabled us to report more accurately against the new Ambulance standards. 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 undertake the actions outlined in our improvement plan.								
14. e)	Category 3 – Urgent – 90th Percentile Response Time (mins)	M8–11 2018/19	**146**	120	285	87	178	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Isle of Wight NHS Trust went live with a new CAD system in October 2018; this change enabled us to report more accurately against the new Ambulance standards. 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 undertake the actions outlined in our improvement plan.								
14. f)	Category 4 – Less Urgent – 90th Percentile Response Time (mins)	M8–11 2018/19	**192**	180	311	123	201	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Isle of Wight NHS Trust went live with a new CAD system in October 2018; this change enabled us to report more accurately against the new Ambulance standards. 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 undertake the actions outlined in our improvement plan.								
15	Patients with suspected ST elevation myocardial infarction who received an appropriate care bundle	Jan/Apr/Jul/ Oct 2018	**79.2%**	n/a	65.6%	90.6%	77.9%	
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 therefore 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.								

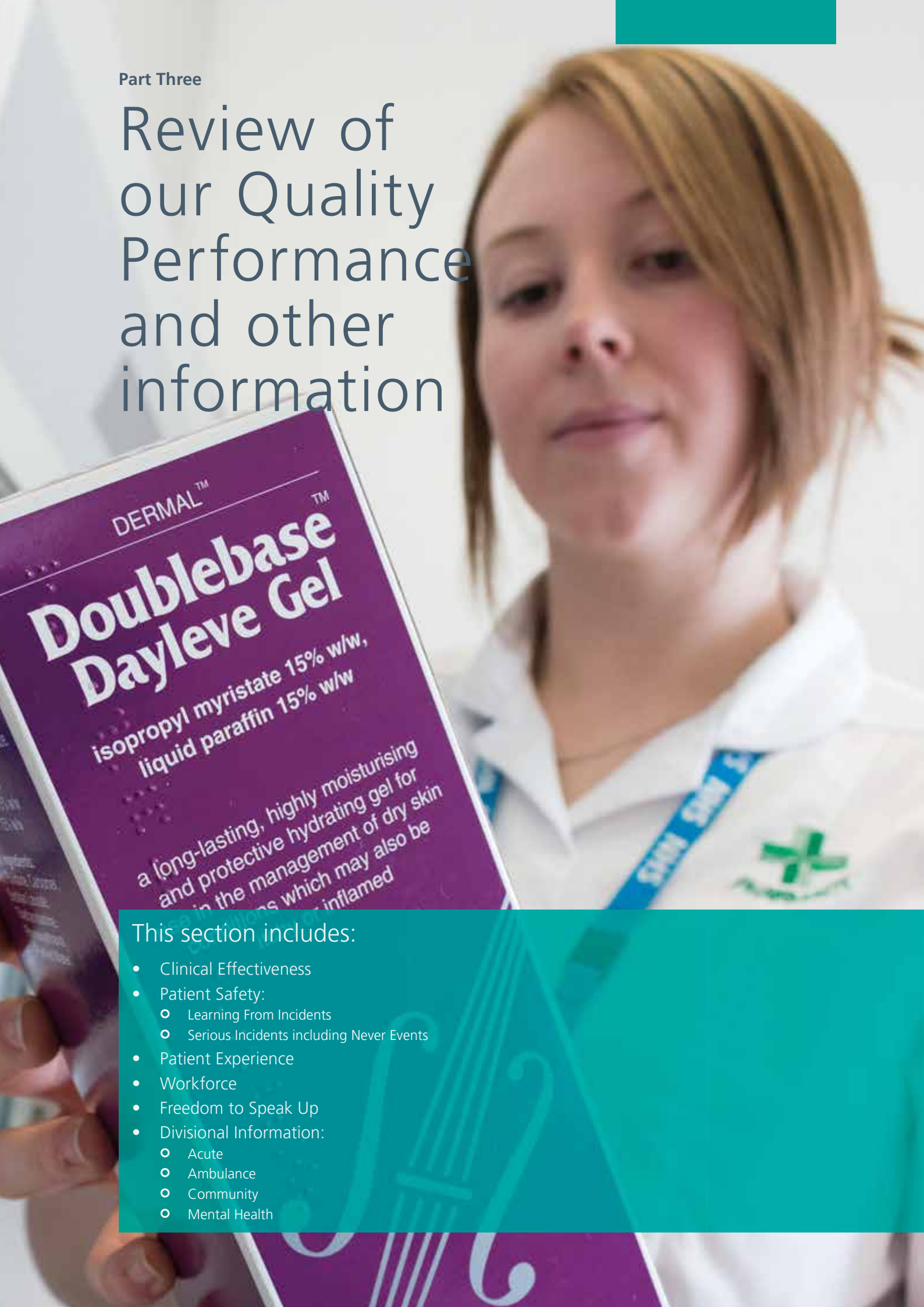
		Data from Health & Social Care Information Centre – Indicator Portal						
Ref.	Indicator description	Period	IW NHS Trust performance	National target	National worst	National best	National average	Performance
16	Patients with suspected stroke assessed face to face who received an appropriate care bundle	Feb/May/Aug 2018	**100.0%**	n/a	94.8%	100.0%	98.2%	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The range in performance nationally for this indicator is small and our performance continues to compare well against other Ambulance Trusts. 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.								
17	Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team	Q1–3 2018/19	**87%**	95.0%	87.0%	100.0%	98.1%	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: All data is validated prior to submission however the numbers for our organisation are small and this can have significant impact on our % Performance. The service lead is working to improve processes to minimise the number of future breaches. 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.								
18 i)	Patient Reported Outcomes Measures (PROMS) for elective procedures – (i) Groin Hernia Surgery	2017/18	**0.07**	n/a	-0.20	0.74	0.09	
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.								
18 iii)	Patient reported outcomes measures for elective procedures – (iii) Hip Replacement Surgery	2018/19 (Apr – Sep)	**0.51**	n/a	-0.05	1.02	0.48	
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 hip patients participate as possible.								
18 iv)	Patient reported outcomes measures for elective procedures – (iv) Knee Replacement Surgery	2018/19 (Apr – Sep)	**20.2**	n/a	1.5	29.0	17.4	
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 knee patients participate as possible.								
19 i)	Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percent, 16+ years	2011/12	**8.8%**	n/a	17.2%	4.9%	11.5%	
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: Continuously 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.								

		Data from Health & Social Care Information Centre – Indicator Portal						
Ref.	Indicator description	Period	IW NHS Trust performance	National target	National worst	National best	National average	Performance
19 ii)	Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percent, <16 years	2011/12	**10.1%**	n/a	14.9%	5.1%	10.0%	
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 children's 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.								
20	Responsiveness to the personal needs of it's patients (Score out of 100)	2017/18	**65.10**	n/a	60.50	85.00	68.58	
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 patient feedback on the quality of services, making feedback mechanisms more accessible and discussing feedback from patients at Trust Board.								
21	Staff who would recommend the trust to their family or friends	2018	**41.1%**	n/a	41.1%	86.8%	70.0%	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Trust continues to go through a period of organisational change which has impacted 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 implemented 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.								
21.1	Patient Friends & Family test, combined result for A&E	Dec–18	**97.0%**	n/a	42.9%	100.0%	87.2%	
	Patient Friends & Family test, combined result for Inpatients	Dec–18	**95.2%**	n/a	80.8%	100.0%	95.9%	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The Trust is continuing 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.								
22	Patient experience of community mental health services	2018/19	**67.5**	n/a	67.5	81.9	74.3	
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 patient feedback on the quality of services, making feedback mechanisms more accessible and discussing feedback from patients at Trust Board.								
23	Patients admitted to hospital who were risk assessed for venous thromboembolism	Q1–3 2018/19	**98.0%**	95.0%	70.9%	100.0%	95.4%	
The Isle of Wight NHS Trust considers that this data is as described for the following reasons: The organisation is currently exceeding the national target of 95% for 2018/19. 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.								

		Data from Health & Social Care Information Centre – Indicator Portal						
Ref.	Indicator description	Period	IW NHS Trust performance	National target	National worst	National best	National average	Performance
24	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	2017/18	**21.26**	n/a	91.0	0	13.21	
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: 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.								
25 i)	Patient safety incidents and the % that resulted in severe harm or death. (i) Total Incident rate per 1000 Bed Days.	Oct 17 – Mar 18	**33.3**	n/a	158.3	14.9	45.5	
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.								
25 ii)	Patient safety incidents and the % that resulted in severe harm or death. (ii) % Incidents that resulted in severe harm or death.	Oct 17 – Mar 18	**0.0%**	n/a	434.0%	0.00%	26.71%	
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.								

Part Three

Review of our Quality Performance and other information



This section includes:

- Clinical Effectiveness
- Patient Safety:
  - Learning From Incidents
  - Serious Incidents including Never Events
- Patient Experience
- Workforce
- Freedom to Speak Up
- Divisional Information:
  - Acute
  - Ambulance
  - Community
  - Mental Health

Clinical Effectiveness

Hospital Standard Mortality Ratio (HSMR)

HSMR is the ration of observed to expected deaths and a measure of healthcare quality.

The latest mortality indicators for the Isle of Wight NHS Trust Dr. Foster report January 2019.

Hospital Standardised Mortality Ratio (HSMR) & Standardised Mortality Ratio (SMR).

- HSMR remains statistically 'significantly lower than expected' – 70.5 (CL: 71.7–86.5).
- Weekday 'below expected'.
- Weekend 'below expected'.
- Standard mortality Ratio (SMR) remains statistically 'significantly lower than expected' – 73.0.

For many years this Trust has been compared to trusts in a 'regional' group however these trusts are very different in type, size and demographics. From spring 2018 this Trust asked for comparators to trusts more similar (Integrated or carrying a similar number of patient superspells) to this one and again this Trust has a significantly lower HSMR than all but one of those trusts.

Full details of the trusts for comparison are contained within the glossary.

Analysis by weekday or weekend admission shows that the emergency weekday relative risk is statistically 'below expected' whilst emergency weekend relative risk is statistically 'as expected' compared to acute non-specialist trusts across England.

Summary Hospital-level Mortality Indicator (SHMI)

SHMI is the ratio between actual and expected deaths following hospitalisation. It includes deaths which occurred, inside and outside of hospital, within 30 days of discharge.

The most recent SHMI for the Trust (23.5.19) is 0.99 which is a continued reduction on the previous quarter/year (previous quarter 1.05).

Get It Right First Time (GIRFT)

Get It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.

The Trust has undertaken a lot of work to implement GIRFT, and good progress has been made so far below:

- Ears, Nose and Throat (ENT) speciality.
  - Predicted improvement of paediatric day case tonsillectomy to 80% with new pathway.
- Orthopaedics.
  - Already saved 32% on loan kit costs over three month period.
- Ophthalmology.
  - Good engagement with Emergency Care and Treatment Plan (ECTP) High Impact Intervention.
  - Purchase of Optical Coherence Tomography (OCT) scanner.
  - Improved intravitreal injection pathway.

Current priorities:

- Establishing and promoting a recognised governance process for GIRFT at the Trust.
- Planning for change of service provision in Urology.
- Assurance of service provision around services not provided by Trust.
- Understand pathway changes that may negatively impact demand on Radiology service.

Visits which have been made to the Trust already and upcoming visits are detailed below:

Clinical visit Date	Specialty
12 06 18	Ears, Nose and Throat
01 08 17	Obstetrics and Gynaecology
03 08 17	Ophthalmology
1/9/14, 11/9/18, 1/3/19	Orthopaedic (+ revisits)
19 09 16	Urology
13 06 17	Oral & Maxillofacial (under Portsmouth)
3/10/18	Emergency Medicine
14/11/18	Imaging & Radiology
11/3/19	Breast Surgery
15/3/19	General Surgery
30/4/19	Diabetes
17/5/19	Wessex Regional GIRFT Stroke Event
18/6/19	Hospital Dentistry
12/7/19	Endocrinology

What is a Serious Incident?

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response (as defined in the NHS Serious Incident Framework 2015).

Patient Safety

Learning from Serious Incidents (SI)

Since last year's 2018 Quality Account, improvements in the SI process have included integrated working with the Isle of Wight Clinical Commissioning Group (IWCCG). This was introduced to:

- Avoid duplication of tasks.
- Seamless sharing of reports and data, as appropriate.
- Direct check and challenge of SI final reports by IWCCG representative attending the Trust's Integrated Panel meetings.
- Use of closure checklist by both IWCCG and Trust, giving an assurance and feedback mechanism.

The Trust has continued to align its SI process in line with the NHS Serious Incident Framework (2015). More recently, the process has been further strengthened to ensure efficiency of process and resources, including the following:

2017 / 18

2018 / 19

The revision to process has been discussed with divisional leads; there is an expectation that any incidents that occur outside of the weekly patient safety summit that look likely to be SI reportable, will be escalated directly for SI reporting, and will not be expected to be held over until the next meeting. This will ensure that NHSI (National Health Service Improvement) and IWCCG are informed in a timely way, including the opportunity to mitigate any further risk at the earliest opportunity.

Levels of Serious Incidents

The following SI levels are still current within the SI National Framework 2015:

- Level one – Concise internal investigation.
- Level two – Comprehensive internal investigation.
- Level three – Independent investigation.

The National Framework is currently being revised and is due for release sometime in Spring

2019; the expectation is that the above levels will be superseded but this is yet to be confirmed

In 2018/19 the Trust had a total of 10440 incidents reported, compared to 9766 in 2017/18. On analysing the data, the level of harm has decreased during 2018/19.

In 2018/19 the top five subjects of serious incidents in comparison to 2017/18 are detailed in the table to the right. It must be noted that some of these incidents are still under investigation and therefore could be downgraded. The final figures would be reflected in 2019/20 Quality Account.

	2017/18	2018/19	
Delay in Treatment	19	25	▲
Unexpected Death	23	25	▲
Patient Slip, Trip, Fall	16	12	▼
Sub-optimal care of deteriorating patient	11	17	▲
Confidential Information Leak	7	Not in top 5	▼
Medication Incidents	Not in top 5	13	▲

Key Performance Indicators

Key Performance Indicators (KPIs) are local indicators to monitor the timeliness of the SI process and also to ensure the mitigation of the risk of a similar patient safety incident occurring.

Serious incident reported within two working days of awareness to report.

- Three working day deadline for completion of 72-hour report (initial findings).
- Immediate actions taken to mitigate risk, recorded in the 72-hour report.

KPI	Detail	RAG	Comment	(Oct) 2017/18	2018/19
1	Serious Incident reported within 2 working days of confirmation	R	75% or less		✓
		A	76% – 80%	✓	
		G	81% or more		
2	Deadline for completion of 72-hour report (3 working days)	R	75% or less	✓	✓
		A	76% – 80%		
		G	81% or more		
3	Immediate actions taken identified in 72-hour report, on first submission	R	75% or less	✓	✓
		A	76% – 80%		
		G	81% or more		

KPI one This has recently been reviewed at Executive level; we are confident that the recent changes to process, as indicated earlier, will result in an improvement to this KPI.

KPI two As we approach the tail end of the financial year, we are already beginning to see an improvement in 72-hour reports being completed at an earlier stage; the new process will also help focus on the completion of these reports, as initial findings will need to be identified to assist in the management of the incident and its decision making.

KPI three We recognise this also needs improvement; the average score was up by 10% on last year. NHS Improvement and IWCCG have more recently been reviewing all SI related 72-hour reports and staff have been reminded of the need to evidence immediate actions taken.

SI Policy

As well as the national framework available, a local Serious Incident Policy is also available – the SI policy is to help ensure that the Trust is using serious incident investigations effectively and delivering meaningful learning to support the quality and safety of patient care and patient experience.

Patient Safety Incidents

The Trust aims to provide care that is safe, effective and high quality for all patients and service users. One of our priorities is 'Lessons Learned' with the aim to actively learn lessons from patient safety incidents, serious incidents (SIs) and Never Events. Learning lessons allows us as an organisation to understand the causes of the incidents and to take the appropriate action to avoid reoccurrence. Therefore, we need to ensure the organisation has a strong incident reporting culture (i.e. a high level of incident reporting), which is a sign of a good patient safety culture.

Figures 1 and 2 detail the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) report, published March 2019.

Figure 1: Potential under-reporting of incidents to the NRLS, April 2018 – September 2018.

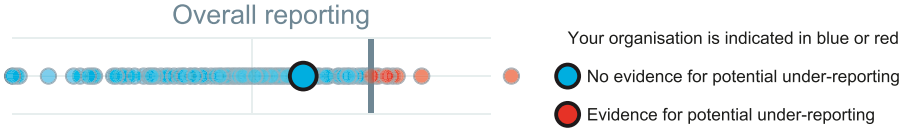


Figure 2: Your reporting rate per 1,000 bed days, April 2017 – September 2017 compared to April 2018 – September 2018.

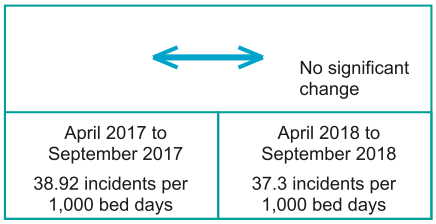
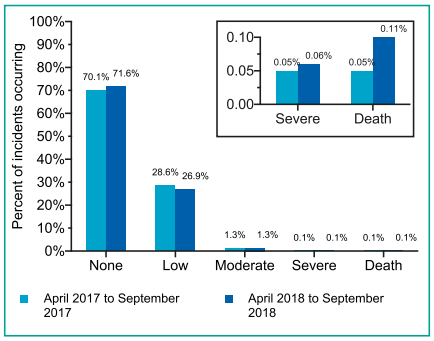


Figure 3 shows the incidents reported by degree of harm and is taken from the latest NRLS data report, published March 2019.

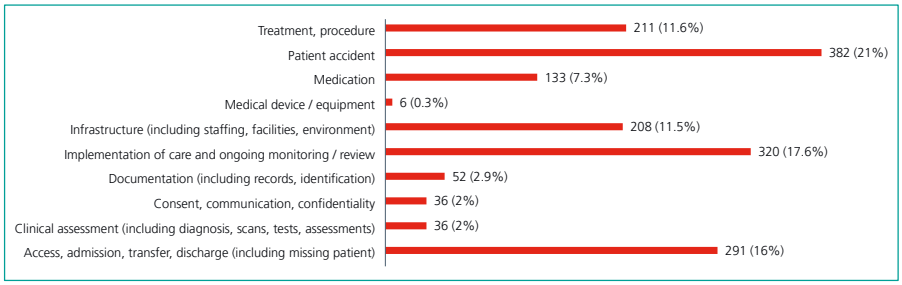
Figure 3: Incidents reported by degree of harm for the period April 2018 – September 2018.



Degree of harm, April 2018 to September 2018

None	Low	Moderate	Severe	Death
1,300	488	24	1	2

Figure 4: The top ten types of patient safety incident for the period April 2018 – September 2018 are detailed in.



Serious Incidents including Never Events

Total number of Never Events and Serious Incidents (SIs) declared in each year:	2016/17	2017/18	2018/19
Total Serious Incidents declared (includes Never Events)	63	149	179
Those subsequently downgraded	4	31	37
Total	**59**	**118**	**142**

Types and numbers of Serious Incidents (SI) declared during 2016/17, 2017/18 and 2018/19
(downgraded cases have **not** been included in chart below)

Serious Incident type	2016/17	2017/18	2018/19
Other	2	5	3
Allegation against Healthcare professional	1	0	1
Sub-optimal care of deteriorating patient * (NB: This SI type is linked to failing to recognise the deteriorating patient)	3	11	17
Delay in Treatment * (NB: This SI type is linked to failing to recognise the deteriorating patient)	21	19	25
Delayed/missed diagnosis	0	3	8
Surgical/invasive procedure issues	2	4	5
Slip, Trip, Fall	7	16	12
Pressure ulcer (PU) (grade 3 or 4)	5	2	11
Unexpected Death	9	23	25
Confidential Information Leak	3	7	0
Medication issues	1	5	13
Screening or scanning issues	1	2	3
Never Event – Retained Foreign Object post procedure	2	0	0
Never Event – Wrong route administration of Medication	1	0	0
Never Event – Wrong Site Surgery	1	0	0
Never Event – Unintentional connection of patient requiring oxygen to air flowmeter (New for 2018/19)	N/A	N/A	1
Clostridium difficile (C. Diff) or healthcare acquired infection (HCAI)	0	2	2
Failure to obtain consent	0	2	1
Serious self-inflicted injury/attempted suicide	0	5	3
Failure to act upon test results	0	2	1
Hospital transfer concerns	0	2	1
Safeguarding vulnerable adults/child	0	4	4
Abscond	0	3	1
Premature discharge	0	0	2
Medical equipment/devices	0	1	3
Totals	**59**	**118**	**142**

Assurance And Monitoring

Assurance and monitoring is via the following pathways:

- Monthly Quality Report (via input of statistics monitored by Performance Information Department).
- SI activity report (seen at the monthly Patient Safety Sub-Committee meetings).
- Quality Committee report (seen at the Quarterly Quality Committee meetings).

The Patient Safety Sub-Committee is responsible for reviewing themes and trends arising from SIs, including sharing the learning arising following an investigation. The Committee is also made aware of any successes and difficulties arising from the serious incident process.

Never Events

The revised Never Events framework (Jan 2018) will be aligned with a new Serious Incident framework due to be published later in 2018* (*now due Spring 2019). The plan is to align the Never Event framework with the Serious Incident framework, as Never Events should always be treated as Serious Incidents.

Regrettably, there was one Never Event reported in 2018/19.

Unintentional connection of air instead of oxygen – The Never Event that was added to the Framework in 2018.

What is a Never Event?

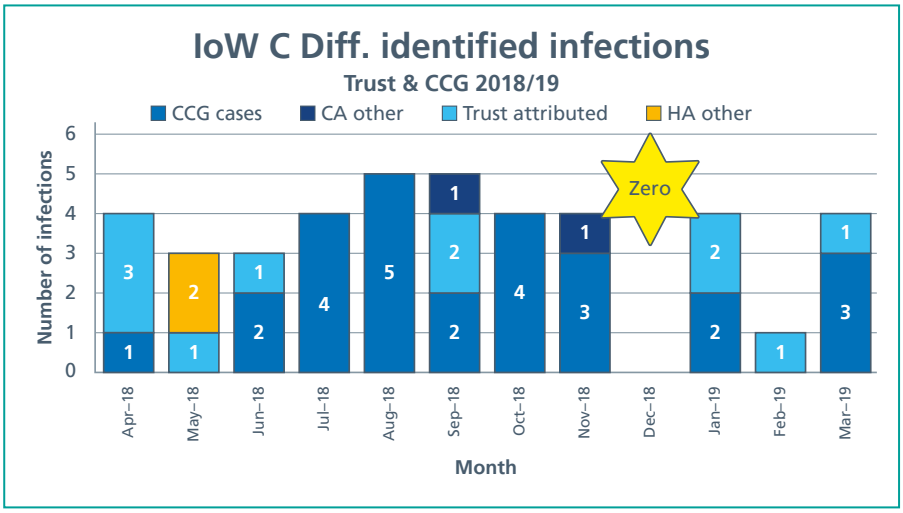
Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Healthcare Associated Infections (HCAI)

The Isle of Wight NHS Trust has continued to focus work on improved management and reduction of incidences of HCAI this year. The overall trends in HCAI have been monitored through the Infection Prevention and Control Committee and reported in the monthly Quality Report. The Infection Prevention and Control Annual Report 2018/19, to be published shortly, will contain more detailed information.

Clostridioides (Clostridium) Difficile Infections (CDI)

The total number of Isle of Wight CDI cases has reduced by 40% from the 2017/2018 figures (65:39) this has been positively impacted upon by a number of factors including good antibiotic stewardship, a programme of enhanced cleaning, refurbishment and upgrading of dirty utility rooms and ongoing staff and patient education.



Graph taken from Internal Mandatory Surveillance database

Trust Attributed C Difficile Infection	Apr–18	May–18	Jun–18	Jul–18	Aug–18	Sep–18	Oct–18	Nov–18	Dec–18	Jan–19	Feb–19	Mar–19	Total
	3	1	1	0	0	2	0	0	0	2	1	1	11

Achieving the low trajectory (target) of only six cases for 2018/2019 represented a challenge due to the demographic profile of the population we serve, the Trust reporting 11 hospital attributed cases. However following Root Cause Analysis (RCA) investigation in conjunction with the Isle of Wight Clinical Commissioning Group (CCG) only two of the 11 cases to date were identified as being preventable.

An RCA was undertaken for all hospital acquired CDI cases. The RCA results confirm that all but two cases were deemed to be non-preventable and that the antibiotics given were appropriate to manage the patient's condition. The following issues were identified as the key service and care delivery factors that may have contributed to the infection or risks for further infections:

- The average length of stay at time of CDI diagnosis for the remainder was 17 days (only one patient in excess of this at 42 days).
- Three patients had history of multiple recent admissions.
- Three diagnoses made on sample taken on day of admission following a recent discharge from hospital.
- There were delays in the sampling of patients with diarrhoea.

What are Healthcare Associated Infections?

HCAIs are infections that patients acquire within a healthcare setting during the course of receiving treatment for other conditions.

What is C. difficile infection?

C. difficile is a type of bacteria that can live in the bowel and cause diarrhoea. The condition most commonly affects people who have recently been treated with antibiotics, but can be easily spread to others.

- There were delays in isolating patients with diarrhoea.
- One incidence of issues with the compliance with Trust prescribing of antimicrobials at discharge.

The Trust now use a Red, Amber, Green (RAG) rating to identify the level of cleaning required for the most commonly presenting infection prevention issues, this has been successfully implemented within the hospital incorporating the use of chlorine based cleaning fluid. This rag rating system identifies the type of cleaning is required and if there is a need for Ultraviolet light in the Clostridium spectrum (UV-C) or Hydrogen Peroxide Vapour (HPV) decontamination. The Trust continues to employ the Hydrogen Peroxide Vapour (HPV) decontamination system for the cleaning of any area from which a patient with a CDI has been discharged or transferred.

A deep clean programme was commenced in 2018 with three medical wards being deep cleaned to date following refurbishment and general maintenance including upgrading of dirty utility rooms in two of the wards.

The main Trust antibiotic guidelines have been updated and made more accessible via an application called Microguide. Inpatient antibiotic prescriptions are regularly reviewed by the Antimicrobial Stewardship team.

Meticillin Resistant Staphylococcus Aureus (MRSA) and Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemias (blood stream infections)

There is a national zero tolerance for MRSA Bacteraemia cases. There have been no hospital-attributable cases identified of MRSA bacteraemia during the 2018/19 year to date, this means that the Trust has met this target for the 2nd year running.

The Trust continues to promote the actions from 2017/2018 action plan to improve documentation and auditing practices around catheter insertion and ongoing care.

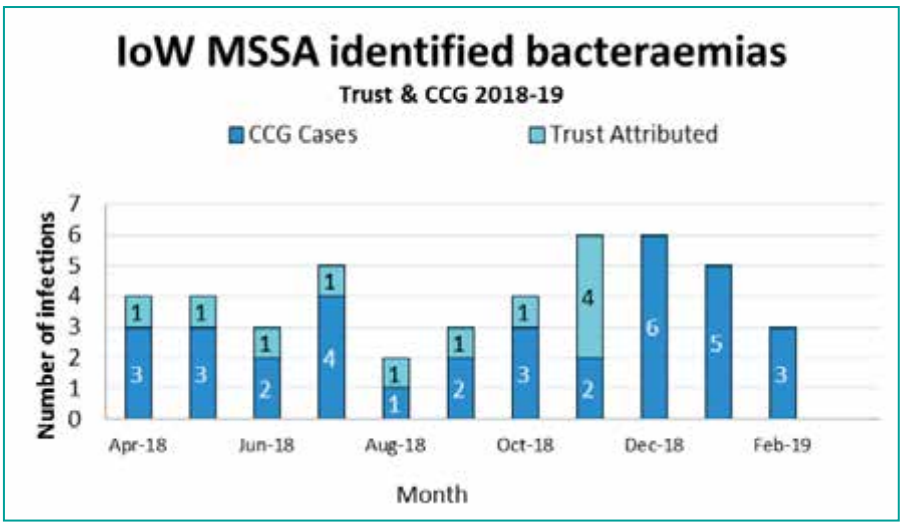
A patient held catheter passport has been developed and implemented by the community nursing service to promote and support best practice and information communication between patients, relatives and healthcare professionals across Primary and Secondary care settings.

Further training has been provided to increase compliance with Aseptic Non Touch Technique (ANTT) practice, for which an audit programme will be included in the 2019/20 Infection Prevention and Control Work Plan.

Methicillin Sensitive Staphylococcus Aureus MSSA bacteraemia 2017/2018

There were a total of eleven MSSA bacteraemia cases attributed to the Trust for the 2018/2019 year to date, although most MSSA bacteraemia were acquired in the community.

Root cause analysis investigations are undertaken for all hospital-attributable cases. Themes identified as a result of these investigations mimic the findings of a need for improved documentation and auditing processes in relation to any indwelling devices e.g. peripheral cannulae and catheters.



Graph taken from Internal Mandatory Surveillance database

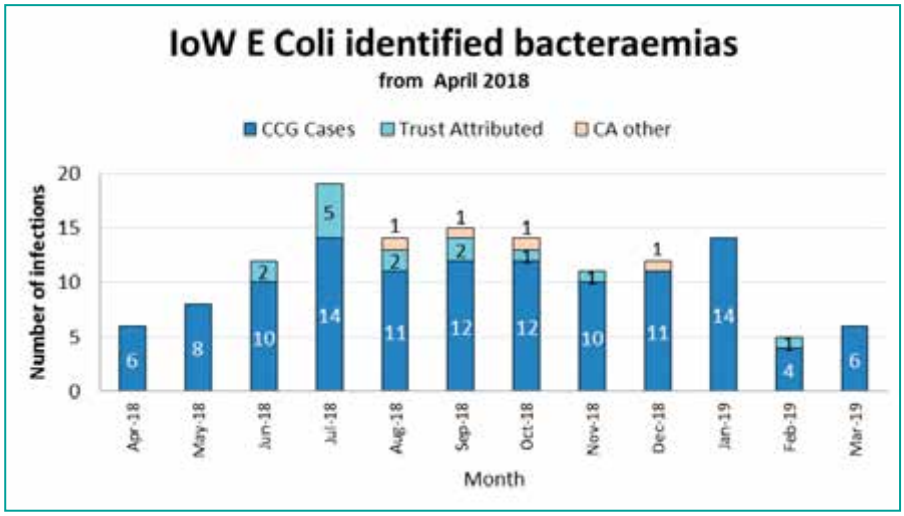
Trust Attributed	Apr–18	May–18	Jun–18	Jul–18	Aug–18	Sep–18	Oct–18	Nov–18	Dec–18	Jan–19	Feb–19	Mar–19	Total
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	1	1	1	1	1	1	4	0	0	0	0	11

Escherichia Coli (E. Coli) bacteraemia surveillance

There were a total of 14 cases of E. coli bacteraemia during 2018/19 attributable to the Trust. This figure represents a reduction from the 22 recorded for the 2017/18 period.

Trust Attributed E Coli	Apr–18	May–18	Jun–18	Jul–18	Aug–18	Sep–18	Oct–18	Nov–18	Dec–18	Jan–19	Feb–19	Mar–19	Total
	0	0	2	5	2	2	1	1	0	0	1	0	14

Root cause analysis investigation is currently only undertaken where indicated by the Consultant Microbiologist. The common theme arising from these investigations remains the need to continue to improve our care and management of indwelling urinary catheters and antimicrobial prescribing. A new catheter insertion and management care plan has been developed which is currently being piloted within the Trust.



Graph taken from Internal Mandatory Surveillance database

In response to the government initiative launched in April 2017, to reduce Gram-negative infections by 50% by 2020, the Trust continues to work closely with Primary Care and the Clinical Commissioning Group to effect compliance with this outcome.

What is MRSA?

MRSA is a type of bacteria that is resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. MRSA infections mainly affect people who are staying in hospital although many people are carriers without any ill effect. An infection can be serious, but can usually be treated with **antibiotics** that still work against MRSA.

Patient Experience

Complaints and Compliments

During 2018/19 reporting of complaints data has continued to be part of the performance report to Trust Board and the monthly quality report which is reviewed at the Quality Committee, as well as being reviewed quarterly via the Patient Experience Sub Committee .Complaints data is also shared at various other committees as part of performance reports. The Trust welcomes complaints as a valuable part of patient experience feedback, and allows the Trust to learn lessons to improve and refine services for current and future users of our services.

The Trust's Quality Strategy placed a focus, this year, on improving complaints handling and ensuring that learning from experiences occurred. Key Performance Indicators (KPIs) this year included managing complaints within timescale, reducing complaints regarding staff attitude, dignity and respect and communication and increasing the compliments received.

At the time of reporting the Trust still has work to do to meet the performance indicators, some divisions have achieved the target of responding to complaints within timescale but this is not consistent across the Trust. Overall, of all complaints closed during 2018/19 only 35% of these were within agreed timescales.

While performance has improved from last year (17/18) a breakdown of complaints performance for each quarter has demonstrated improvement as detailed below.

Q1 – 101 Complaints achieved 20%
(managed within agreed timescale)

Q2 – 109 Complaints achieved 30%
(managed within agreed timescale)

Q3 – 137 Complaints achieved 45%
(managed within agreed timescale)

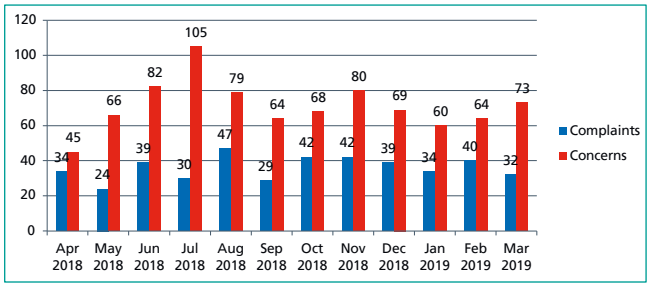
Q4 – 100 Complaints achieved 43%
(managed within agreed timescale)

To help improve the management of all complaints we have further reviewed and streamlined the process.

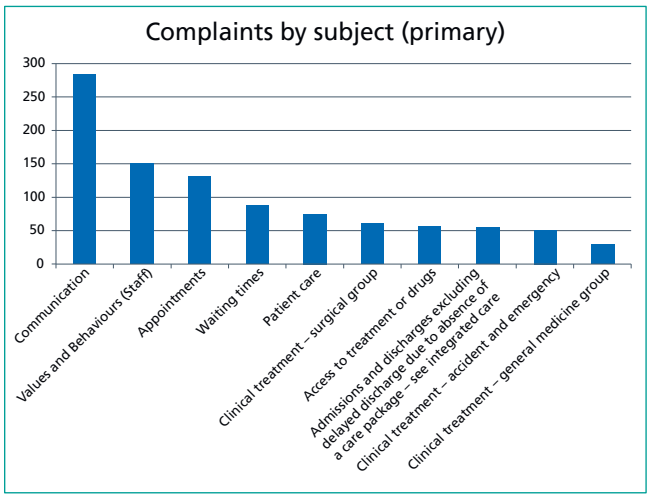
The Trust has continued to focus on the complaints backlog and in order to improve upon this held a complaints amnesty with the support of staff within Care Groups and Divisions.

Some of the improvements made by the Isle of Wight NHS Trust are to ensure that complaints are now investigated and reviewed directly with the staff involved. The patient and/or family members are also involved at the beginning of the complaint investigation to ensure lessons are learned and improvements are being made with the patient and/or family member's involvement. This has been reflected in the Trusts complaints handling with increased local resolution meetings being held and the quality of responses improving.

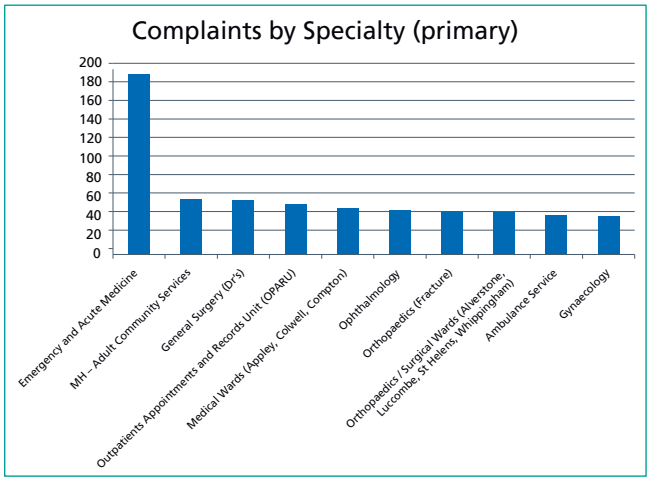
Outlined below is the month on month performance in relation to complaints and concerns. For the purpose of this report, the complaints data includes complaints that have been re-opened, as well as complaints that were also subsequently withdrawn.



The top ten main subject areas across all complaints and concerns are shown below; this is based on the primary subject of the complaint.



The top ten areas receiving the highest number of complaints and concerns are shown below:



Patient Feedback including Friends and Family Test (FFT)

The Trust has continued to offer the Friends and Family Test question across all services in the Trust at either the point of discharge, or during their pathway of care. The question asked is:

In April 2019 the Trust moved to using Membership Engagement Services (MES) to support with the collection of real time patient experience feedback. MES works with a number of healthcare providers to enable patients to leave meaningful feedback on their care. The system enables the Trust services to review and learn from the feedback at an early stage in the feedback process.

The Trust has a total of high number of services currently registered and using the system to capture real-time patient feedback, and a number of services have developed their own bespoke surveys in the system to gain feedback on their services.

Since the introduction and implementation of MES the Trust has received a total of 10,123 reviews of its services and across these received a 90% satisfaction score from all feedback captured during 2018/19. Other mechanisms to enable patients to feedback to the Trust are via the NHS choices and Care Opinion website, via Healthwatch Isle of Wight, the Care Quality Commission or using social media. The Trust and Healthwatch Isle of Wight regularly share information including themes of complaints, concerns and issues raised to ensure wider lessons are learnt and key themes identified.

The following tables provide the 2018/19 Friends and Family Test recommended scores and response rate by quarter for the required submission areas:

2018/19 Friends and Family Test Recommended and Response Rate:

		Target	Q1	Q2	Q3	Q4
Inpatients	Recommended	> 95%	95.0%	97.0%	97.0%	96.7%
	Not recommended	< 5%	1.0%	0%	2.0%	0%
	Response rate		10.5%	11.9%	19.1%	21.0%

		Target	Q1	Q2	Q3	Q4
Mental health & learning disabilities	Recommended	> 95%	98.0%	97.0%	96.0%	98.0%
	Not recommended	< 5%	0%	0%	1.75%	0%
	Response rate		1.4%	0.96%	1%	0.94%

		Target	Q1	Q2	Q3	Q4
Maternity (birth)	Recommended	> 95%	61.0%	* 27.0%	100%	100%
	Not recommended	< 5%	6.0%	7.0%	0%	0%
	Response rate		5.0%	2.0%	4.5%	0.37%

* only one month data supplied for which recommended score was 80%.

		Target	Q1	Q2	Q3	Q4
Emergency department	Recommended	> 95%	No returns	90.0%	93.0%	93.0%
	Not recommended	< 5%	No returns	5.0%	2.12%	1.6%

		Target	Q1	Q2	Q3	Q4
Outpatients	Recommended	> 95%	63.0%	98.0%	98.0%	98.2%
	Not recommended	< 5%	0%	1.0%	3.0%	0.2%

		Target	Q1	Q2	Q3	Q4
Ambulance	Recommended	> 95%	* 33.0%	** 67.0%	99.0%	100%
	Not recommended	< 5%	0%	0%	0%	0%

* data only submitted in one month of quarter in which 100% recommended score was given.
** data only submitted for two months of quarter, both of which scored 100% recommended.
No responses received for Ambulance (See and Treat) in quarter four.

		Target	Q1	Q2	Q3	Q4
Community	Recommended	> 95%	98.0%	100%	99.0%	95.0%
	Not recommended	< 5%	0%	0%	1.0%	2.0%

The Isle of Wight NHS Trust values feedback from patients, carers and relatives and will continue to build on work undertaken during 2018/2019. The Trust is looking at alternative solutions to support us with ensuring we capture and act on valuable patient feedback.

Patient Surveys

The Trust has continued to participate in the national patient survey programme and below is a summary of the current progress against the programme for the quarter:

Adult Inpatient Survey 2018

The Adult Inpatient Survey 2018 completed during Quarter Four; with results under Embargo until May/June 2019 (TBC). The Trust has received a presentation on its results from the Survey Provider Quality Health, and an improvement plan is in place which will be monitored via the Patient Experience Committee.

National Cancer Experience Survey 2018

The National Cancer Experience Survey 2018 commenced during the Quarter. The Response rate as of 5th April was 68% this is above the overall national response rate of 63%. All adult patients (aged 16 and over), with a primary diagnosis of cancer, who have been admitted to hospital as inpatients for cancer related treatment, or who were seen as day case patients for cancer related treatment, and have been discharged between 1st April 2018 and 30th June 2018 will be eligible for the survey. The survey closed on 12th April 2019, and results area yet to be published.

Community Mental Health Survey 2018

The results of this survey were published on 11th November 2018, the Trust had responses from 217 participants; results showed we were worse than other trusts in eight sections, and about the same in three sections. The results of the survey have been presented to the Division, and actions are being taken forward from this feedback. This is linked to the Quality Strategy to support the Trust in Getting to Good in 2020. Further information on the results can be found at https://www.cqc.org.uk/provider/R1F/survey/6#undefined

Community Mental Health Survey 2019

The Community Mental Health Survey is currently ongoing, with the initial questionnaires distributed. Results are expected to be published November 2019.

Emergency Department Survey 2018

The fieldwork continues to be in progress for this survey, and patients who visited the service during August and September will be eligible for the survey. Results will not be available until 2019. Data sample was due to be submitted on 26th March 2019 to enable analysis. Results are expected to be published August 2019.

Maternity Survey 2018

The results of the survey were published during the Quarter and can be found at https://www.cqc.org.uk/publications/surveys/surveys. 50 responses were received for this survey. Three areas of care are scored and the Trust scored about the same compared with other Trusts.

Labour and Birth 8.9/10; Staff 8.9/10 and Care in hospital after birth 8.0/10

The Trust scored better in one area when compared with other trusts and that was for: Being treated with kindness and understanding by staff after the birth.

Maternity Survey 2019

Early fieldwork for this survey has commenced and the main fieldwork will take place during April – August 2019, with results due to be published in January 2020.

Children and Young Persons Survey 2018

Fieldwork continues for this survey, and patients who were admitted during October 2018 will be eligible for the survey. The fieldwork continues until May 2019. Results are due to be published October/November 2019.

Results of the surveys where the Trust is supported by Quality Health our Survey Provider, are presented to relevant senior staff to enable improvement plans to be developed. The Patient Experience Sub-Committee discuss and review the recommendations and actions taken to ensure the Trust is learning lessons from this valuable patient feedback

Workforce

National Annual Staff Survey 2018

Our National Annual Staff Survey results have been published and we are working with our teams to prioritise our focus on actions to support improvements in scores.

Staff Survey responses were disappointing but we must remember that the survey was undertaken six months ago. We have been asking staff the key questions from the Annual Staff Survey and the Friends and Family test for staff on a monthly basis through a local survey named the Pulse Check. This Pulse Check survey has been able to demonstrate an up to date gauge of how staff are feeling and whether they would either recommend the Trust as a place to work and whether they would recommend the Trust as a place to receive care and treatment. The last three months data show a promising increase in positive responses from staff. This data is published onto the staff survey page of the Intranet for all staff to see.

Staff Engagement

This result is measured as an average across three themes: Advocacy (recommendation of the Trust as a place to work or receive treatment), Motivation (staff motivation at work) and Involvement (ability to contribute towards improvement at work). The table below shows that across the services (those that are comparable) the Trust has declined in this score and three of the four sectors are rated lowest in the country for staff engagement. The Community Division did not receive a separate report last year as they were incorporated into the Acute Division report for 2017.

	Service	IOW in 2018	IOW in 2017	Staff Engagement ranking in benchmark group 2018	National Average 2018
Overall Staff Engagement Score NB: Acute & Community were combined 2017 so the data is not comparable.	Acute	6.40	6.58 Not comparable	37th (out of 38)	6.93
	Ambulance	5.58	6.00	5th (last)	6.08
	Mental Health	6.12	6.29	10th (last)	7.09
	Community	6.08	Not comparable	10th (last)	7.08

Report details taken for the Annual staff survey 2018.

Other staff experience indicators taken from the annual staff survey results 2018

Please note that the survey is split into four Divisions (described as Organisations), for Isle of Wight NHS Trust, due to the unique integration.

Questions taken for the Annual NHS staff survey 2018	Acute sector	Ambulance sector	Community sector	Mental Health sector
Q3c) I am able to do my job to a standard that I am personally pleased with.	74.4% (79.6%)	75.5% (78.2%)	70.3% (76.2%)	70.8% (76.5%)
Q4d) I am able to make improvements happen in my area of work.	49.8% (56.1%)	46.7% (32.4%)	50.1% (58.1%)	49.3% (61%)
Q21 If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	39.8% (71.3%)	43.7% (71.4%)	36.8% (74.8%)	38.2% (61.3%)
Q19g) My manager supported me to the receive this (relevant) training, learning and development.	49% (54.1%)	57% (42.7%)	49.3% (56%)	52% (60.2%)

* (bracket data) showing the average sector benchmark score.

All four sectors (Divisions) in the National Staff Survey results have been triangulated with the Friends and Family Test for staff and monthly Pulse Check survey highlights areas of concern regarding the experience of staff working at Isle of Wight NHS Trust. In total only ten questions have improved in their responses across all four Divisions and a total of 61 have declined in their response since the 2017 survey, however we should recognise that the 2018 survey was conducted six months ago (during September/October 2018). We must ensure that we closely monitor the FFT for Staff and monthly Pulse Check for more accurate and up to date data. Division action plans are expected to be completed by the end of April 2019.

Planning and Developing the Workforce

Through our future careers and volunteers service we promote NHS careers. Working with local education providers to provide work experience and volunteering opportunities in support of our strategy of 'growing our own future workforce'. In 2018, one of our Volunteer's was nominated and was awarded 3rd place for national award 'Young Volunteer of the Year'.

We are committed to supporting our staff with career aspirations through a personal development plan which guarantees an annual appraisal and time off for training and development. During the 2018/19 we have;

- Launched our Professional Development Frameworks for Clinical staff in bands 2–8,
- Implemented a two week Clinical Induction for registered and non-registered staff commenced January 2019,
- Refreshed our Preceptorship Programme for Newly Registered Practitioners,
- Implemented a Clinical Bands 2–4 Education Pathway,
- Ongoing Record of Competence for Registered Nurses in Development (April 2019),
- Ongoing Record of Competence for AHPs in Development.

Health and Wellbeing

This year we have invested in our Occupational Health (OH) Services to provide dedicated support to our staff that have experienced stress, anxiety and depression. Our OH Mental Health Practitioner has been focusing on improving and providing resilience support to help prevent absence and by providing early interventions to staff during episodes of sickness absence.

Working in partnership with our Physiotherapy Teams, through our Occupational Health service we have been able to provide staff with Physiotherapy support. Over 300 employees have been referred to the rapid access Physiotherapy service during 2018/19 and the majority felt it helped prevent them going off sick and had a positive effect on both their work and home life.

Our active health and wellbeing group continue to engage with staff on a range of initiatives and during 2018/19 this included the relocation of our outdoor gymnasium on our St. Mary's Hospital site, promotion of healthy eating, holding health and wellbeing events including health checks, access to exercise classes, Cycle to Work schemes and referrals for weight management.

Workforce Challenges

As a Trust providing services to an island population we are faced with some unique circumstances which offer both additional challenges and, at the same time, opportunities. There are known national skills shortages and our geographical location can be viewed as a unique selling point, however this can also create challenges in our ability to attract and retain the very best.

Apprenticeship schemes were launched for Registered Nurse Degree Apprenticeships (RNDA) and 14 start in September 2018, Trainee Nursing Associate Apprenticeships (10 starts February 2019) to support our 'grow our own' future workforce. Further recruitment in place for the following: RNDA September 19-up to 15 starts, September 2020-up to 15 starts, TNA September 19-up to 20 starts, February 2020-up to 20 starts, September 2020-up to 20 starts.

- Working in collaboration with service leads our Clinical Lead for e-Rostering and Safe Care is providing additional scrutiny to our acute and mental health wards on rostering compliance. This oversight provides challenge to ensure rostering practice is compliant to policy, meets safer staffing requirements and improves planning.
- Signed the Step into Health Pledge to offers an access route into employment and other career development opportunities within the NHS to members of the Armed Forces community.

- Maximising national workforce supply opportunities; attendance at recruitment fairs planned quarterly with hosted 'welcome days' on the Island to promote our employee value offer.
- The Recruitment Team shortlisted as a finalist for the 'Best Recruitment Experience' by Nursing Times workforce summit awards in October 2018.
- Implemented an international recruitment campaign for Registered Nurse vacancies.
- Relaunched our recruitment brand 'Great place to live, great place to work'.
- In June our Careers Facebook page went live in to promote the diverse range of careers in the NHS and the opportunities we offer locally on the Island, we want to grow our future workforce from our local community.
- We reviewed our recruitment processes to reduce our time to hire and continue to work on streamlining our systems and processes.

Freedom to Speak Up

Guidance note

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS Trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust.

Goal

To have a healthy speaking up culture where staff have the knowledge and confidence to raise concerns and that they are supported through the process.

Introduction

The Freedom to Speak Up independent review into creating an open and honest culture in the NHS (2015) recommended the widespread introduction of the Freedom to Speak Up Guardian (FTSU) role in each NHS organisation. Leisa Gardiner took up this Guardian role in October 2016.

Vision

Freedom To Speak Up Vision:

"We are committed to promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out".

Why is it important to us?

Having effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust. Speaking up about wrongdoing at the earliest opportunity can save lives, prevent harm and protect organisational reputation.

How will we achieve this?

The Trust has a nominated Freedom To Speak Up Guardian who is supported by a team of Freedom To Speak Up Advocates and Anti-Bullying Advisors. The team will provide support for the workforce to raise and respond to concerns in relation to patient safety, bullying and harassment and any other concerns by ensuring an environment of trust, openness and respect. The Freedom to Speak Up Guardian will help to raise the profile of raising concerns in the organisation. Provide confidential advice and support to staff in relation to concerns they have and/or the way their concern has been handled. Facilitate the raising concerns process where needed. Ensure the organisational policies are followed correctly.

When a staff member raises a concern either through the Freedom To Speak Up route or via an Anti-Bullying Advisor, a meeting is arranged to meet with the staff member. At the meeting the concern is heard, the member of staff is supported and options how their concern can be dealt with are discussed. Where appropriate, concerns are escalated and direct access is available to the Chair and Chief Executive Officer. Ongoing contact and support is available to the staff member until they feel their concern has been addressed or resolved. A feedback form is sent to the staff member who has raised the concern to ask whether they felt supported and would raise a concern again.

How will we know we are successful?

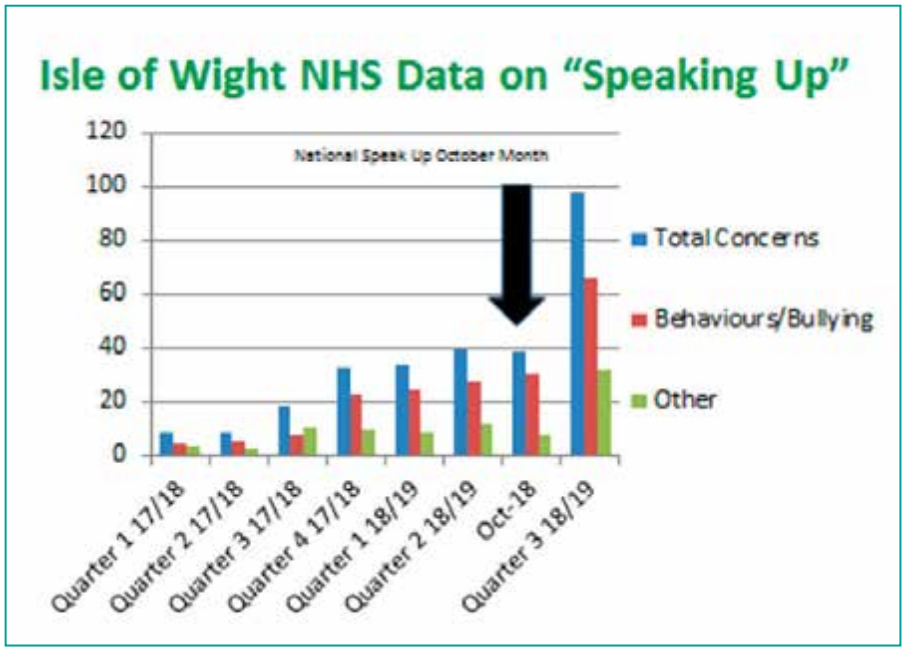
Freedom To Speak Up is one component of a wider strategy to develop the Trust as a more open and inclusive place to work. The National NHS Survey asks two questions about staff raising concerns in their Trust.

Q13a Know how to report unsafe clinical practice

Q13b Would you feel secure raising concerns about unsafe practice.

An increase in the % rate of staff who responded positively to these questions would be a measure of improvement.

Our Data



What we have achieved

- October 2018 recruitment of four additional Freedom To Speak Up Advocates and seven Anti-Bullying Advisors.
- Raising Concerns (Whistleblowing Policy) Updated January 2019.
- October 2018 – National 'Speak Up' October month, which involved holding staff awareness sessions and raising the profile of speaking up through staff communications and visiting teams.
- Board Self-Assessment undertaken in February 2019.
- Freedom To Speak Up Guardian was asked to speak at an NHS conference on how the Isle of Wight NHS Trust is tackling Bullying Behaviours.
- The Freedom To Speak Up Guardian is jointly leading on the Culture and Leadership Programme for the Trust and has been directly involved in the development of the Behaviours Framework and in helping to create a compassionate workforce.

Vision and Values

The Isle of Wight NHS Trust is on a journey to get to 'Good'. That means looking at all the ways we can improve our care and services for the benefit of both our patients and our staff. During 2018/19 we embarked on a culture and leadership improvement programme. We engaged with over 600 staff and patients/service users to understand more about our culture to strengthen our culture of compassion. As an outcome of this work we have restated our organisational values; **CARE** is the golden thread through everything we do.

Compassionate

To provide compassionate care by creating a climate that encourages actively listening to each other, understanding each other's perspectives, empathising, and taking appropriate action to help and support each other. Working with our patients and service users in joint decision making.

Team working

To encourage teams to listen carefully to each other, understand all perspectives, and offer support and help to each other.

Improving

To continuously develop, learn and try new things to become more efficient.

Valued

Treating people as individuals, recognising staff contribution and the needs of those who use our services.

Our loyal workforce continues to give unselfishly to maintain services. We are proud of what they do and, through our workforce strategy we aim to be in the top 20% of NHS employers and to have the best possible reputation locally, and beyond. We want our staff to have the right tools and support to flourish.

Staff engagement

Our workforce and leadership strategies are designed to address our challenges, build on our successes and to achieve "A Great Place to Work". We believe that delivering high quality care for patients and service users means building a culture in which staff feel supported, respected and valued. A compassionate culture is a priority for the Trust and we believe this happens best when leaders develop teams which are supportive and give both accountability and hold to account.

During 2018/19 we launched our leadership development programme. This programme spans our entire workforce providing opportunities for all our staff across all professional groups to engage and develop within our compassionate leadership model. We will monitor our progress by our new Cultural Dashboard and some of the expected outcomes include improvements in our staff survey results, improvements in the health and wellbeing of our staff, improved clinical outcomes and productivity, compassionate leadership behaviours.

We will be holding a National leadership conference on the 29th March 2019. This conference will showcase the achievements of the Culture and Leadership programme. The aim of the conference is to enable us to explore what compassionate leadership means for leaders and the impact that it has on those using our services across health and care. We have been able to attract national recognised speakers such as; Professor Michael West, Michael McGrath and Peter Lees. After an initial invite to those who have a leadership role within the Organisation as well as our partners across the region, we have now been able to open up the invite to any staff who have registered to attend. There are 251 people booked to attend the conference (22nd March 2019).

The Trust has just completed phase one of the 'Getting to Good Culture & Leadership programme' during this phase we have developed Leadership development programmes for staff working at all levels within the organisation. Appropriate leaders and managers from all Divisions have been invited to action planning sessions to discuss the actions that need to be taken to improve the experiences of staff working within this Organisation. The Leadership Development Team have drafted a high level action plan that has been shared with Divisional leads, which highlights the areas that have been identified as recommendations for improvement by the report provider Quality health. This high level action plan (appendix one), will inform the detail required for the action plans that will be developed by the appropriate leaders of divisions, departments and clinical business units within our Organisation. Divisional action plans will be reviewed at performance review meetings and the Board will be made aware of progress via the monthly board reporting process. On-going improvement actions are listed below as part of our Getting to Good programme, actions which will contribute to the improvement of overall staff experience, engagement and satisfaction.

Source: Getting to Good Phase two booklet

Appraisal plays a key part in the engagement of staff. It is not just an opportunity to discuss development needs and performance but also talk to staff about daily working life and test progress on our initiatives. We are, therefore, focusing our efforts on the content and quality of the policy, appraisals and documentation. A goal of 85% compliance has been set for the organisation.

Appraisal compliance

- Compliance for whole Organisation is at 77.11 % as at 31st March 2019.
- This is a decrease of 0.3%.
- New policy wording for 2019 to be finalised and will be sent to appropriate groups/stakeholders for consultation in late March.
- Data analysis will change as the organisation will measure compliance monthly – starting at 0% for all departments from 1st April 2019.
- Additional training and support for appraisers scheduled and targeted to the leads of departments with the lowest compliance.
- Policy in review to reflect changes as a result of pay deal and appraisal linked to pay progression.
- Engagement and improvement plan to be launched in April/May 2019.

Equality and Diversity

The publication of our Equality and Diversity Strategy in June 2018 provided the Trust with a sustainable delivery model for equality and diversity and to help the organisation respond positively to our legal, regulatory and commissioner requirements, including the Equality Delivery System (EDS2), the Workforce Race and Disability Equality Standards (WRES and WDES) and the Gender Pay Gap.

Equality, Diversity and Human Rights are enshrined in the NHS constitution and are central to everything we do at our Trust. We aim to be recognised as a national leader for the delivery of equality and diversity and our aims are illustrated in our Equality Standard Roadmap to 2022, by embedding equality and diversity into everything we do.

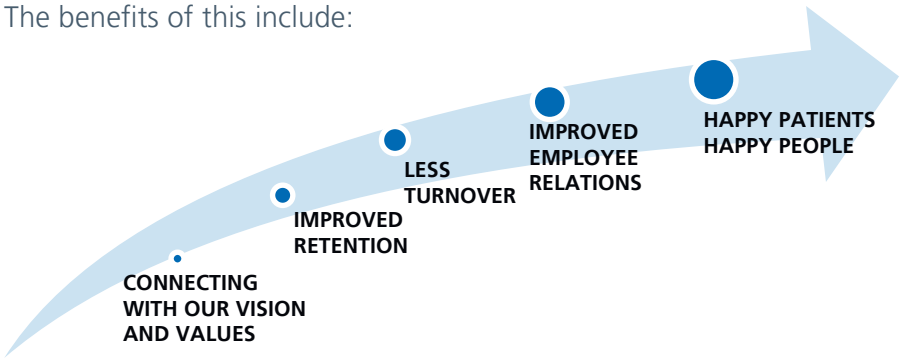
To achieve this we have set ourselves some ambitious targets underpinned by a programme of work for equality and diversity that will be evaluated on positive measurable outcomes for both patients and our staff.

Figure below: Equality and Diversity Roadmap to 2022

Our aims and objective

Our inclusion promise to empower our patients and staff and put them at the centre of everything we do, so that they feel safe to raise issues, make changes happen and recommend the Trust as a place to work and have care and treatment.

The benefits of this include:



A quality service is one that recognises the needs and circumstances of each patient, carer, community and staff member, and ensures that services are accessible, appropriate and effective for all, and that workplaces are free from discrimination where staff can thrive and deliver.

The trust recognises that valuing people as individuals is the greatest possible benefit for everyone who comes into contact with the trust. The needs and circumstances for patients, carers, communities and staff from protected groups can be distinct and specific. In providing quality services and workforce environments that are appropriate and effective for all, the Trust will prioritise and promote equality, diversity and human rights.

EDS 2, WRES, WRDS all seek to achieve a positive measurable outcome for everyone who comes into contact in the NHS. The **Equality Standard** is crucial to developing an understanding of our roles and responsibilities to equality and diversity. It has been designed to mainstream equality and diversity in everything we do and offer incremental recognition of improvement with three award levels: bronze, silver and gold.

Our Equality Objectives have been inspired by the EDS2 Goals:

- Better Health Outcomes for All.
- Improved Patient Access and Experience.
- Empowered, Engaged and Well Supported Staff.
- Inclusive Leadership at All Levels.

To oversee the delivery of the Equality Standard and to support embedding inclusive behaviours the Equality Impact Group (EIG) was established in January 2019.

The Equality Standard will also strengthen our obligation through a 5-step delivery model:

Governance and Reporting (Equality Impact Group
Organisational and Cultural Development (Equality Standard)
Engagement and Involvement (VOX POP and targeted events)
Learning and Development (Diversity Moments)
Employee Relations Performance (Diversity Scorecard)

Since publishing our Equality and Diversity Strategy we have:

- Celebrated Black History month with a series of social events and cultural food in the staff restaurant.
- Established the Equality Impact Group with representation from all clinical and non-clinical divisions of the Trust.

- Completed a corporate self-assessment against EDS2 which was rated at bronze level.
- Delivered Equality and Diversity training and awareness to Clinical Divisional Boards and the Trust Board, so members are now more aware of their equality and diversity responsibilities.
- Refreshed equality and diversity training for line managers to include unconscious bias awareness and updated the Trust's e-learning module.
- Participated in the first Isle of Wight Pride event September 2018
- As a result of change to the Equality Act 2010 (Specific Duties) Regulations the Trust was required to report on its gender pay gap. As at 31st March 2017 the difference in average pay of all men and women employed by the Trust was 19%.
- The results of our Workforce Race Equality Standard (WRES) showed that 95% of our staff reported their race; it highlighted that BME staff are under-represented at senior levels of the organisation; there was an increase in BME staff believing that the Trust provides equality opportunities for career progression and promotion.

Acute Services

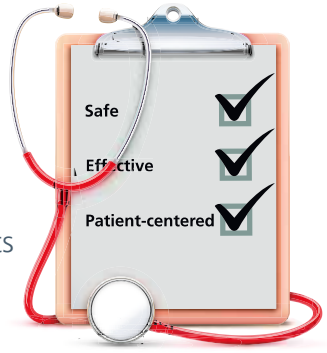
2018/19 Review of Performance against Patient Safety, Quality and Effectiveness

Quality – our number one priority

The Acute Division is the largest division within the Isle of Wight NHS Trust which encompasses the majority of services on the St Mary's site. Employing more than 1433 staff who deliver over 45 different clinical services from the neonatal intensive care unit to care of the elderly, we provide a full range of care to the people of the Isle of Wight. The Division is currently divided into three Care Groups;

- Medicine Care Group – which delivers services across inpatient wards and outpatient facilities.
- Surgery Women's and Children's Health (SWCH) Care Group – delivering elective and emergency surgical care for children and adults, including pathways to tertiary care where appropriate. It also supports the provision of community and acute paediatrics; obstetrics and midwifery services including special care unit for neonates.
- Clinical Support, Cancer and Diagnostics (CSCD) Care Group – delivering a range of specialist services for the Island through a multi-disciplinary workforce that are essential to making every patient's journey the best it can be.

The quality of service that we provide is our overriding priority and the common purpose that brings all of our staff together, no matter what roles they do and where they work, and this is central to both our mission and vision as a Division. In common with the rest of the NHS, we face a significant challenge: delivering the highest quality of services for our patients whilst ensuring future financial sustain ability. This means doing more for less, doing it better and doing it smarter.



Our workforce are key to the delivery of this and we will ensure through a strong focus on leadership and culture change that we have the right people in the right roles that are empowered, motivated and trusted to deliver the level of quality care we expect for our patients.

The division will deliver quality improvements in line with the requirements of the Care Quality Commission assessments and the Trust's 'Getting to Good' agenda and will achieve this:

- Through Good Governance – we have established robust governance systems across the division. This enables us to escalate concerns rapidly and effectively from Ward to Board level.
- By reporting and investigating all incidents and supporting staff to feel able to do this through training and engagement.
- Recognising deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them.
- Implement and embed the national guidance for sepsis and AKI to prevent avoidable deaths.
- Ensure that the Trust is delivering care with improved outcomes that equal or exceed the best in the NHS through transformation of our services that deliver patient centred pathways.
- Ensure that our patients have their care delivered in the most appropriate place from admission to discharge to achieve improved clinical outcomes.
- Create a positive experience for our patients and service users and those closest to them, by engaging through a patient engagement strategy.
- Support the improvement in care of patients who have dementia.
- Ensure that patients at the end of their life have their care delivered in line with their wishes and with the utmost dignity and respect.

Acute Quality Improvement

The Division have taken positive steps to make improvements in all aspects of safety in the last 12 months. We recognise that we are on a journey in 'Getting to Good' and that there are still further improvements to be made in the coming year.

The Division has responded to improving the safety of the service through development and implementation of a Safety Recovery Plan. This plan has provided our services with a framework to monitor progress and impact, and provide assurance that improvements in patient safety have been effective and consistently applied across all areas.

Our progress has been monitored through the three care groups which form our division and are represented at the Quality Improvement Board which reports up through the organisational committees, to the Trust Board.

Whilst the Trust is not meeting all constitutional targets, there has been significant improvement in the monitoring and actions taken to improve patient safety.

We will continue to improve our compliance with reporting and robustly investigate services that could have or did cause our patients or staff harm.

In the last twelve months the key areas acute services have focused on are: documentation, mandatory training, infection prevention and control, staffing levels, incident reporting, safeguarding referrals, mortality reviews and WHO compliance.

Acute Quality Strategy

Implementing the Acute Quality Strategy will improve patient experience by providing high quality treatment, delivered with care and compassion and will support us to continue to embed safety improvements across all of our services. In line with the CQC quality domains of SAFE, EFFECTIVE AND EXPERIENCE we have directly aligned our priorities with the overall Trust Quality Strategy.

The Division is in the process of developing a Patient Engagement strategy to help inform and engage with members of the public to provide us with direct feedback on how we can improve our services for those we serve. This approach will encourage providers and patients to work together, increasing involvement in decision making and improved health outcomes.

Workforce are our biggest asset and as a division we need to ensure that all of our staff feel engaged with service improvements, leadership, and change processes. To support this we will also be developing a Staff Engagement Strategy, aimed at improving the way in which we engage and communicate with our staff and also increasing staff response rates to staff surveys.

The ultimate success of the Strategy will be demonstrated by:

- Being in the top 20% of Trusts in national patient surveys across all services.
- Top quartile for patient safety incident reporting.
- Be able to evidence a clear decrease in identified high risk themes from SI and complaint lessons learned.
- Maintain better than expected mortality levels.
- Achieving constitutional quality targets.
- Achieve the best clinical outcomes in national and local audits.
- Being rated as a minimum of 'Good' by the CQC.

Successes and Opportunities

Safe

- Regular reviews of registered nursing staff vacancies, recruitment and establishments. Overseas recruitment and apprenticeships. Twice daily staffing reviews are undertaken.
- All agency and Temporary staff undertake ward based induction. Long line agency staff given additional training.
- Recruitment strategy working with Human Resources to fill vacancies.
- We have reduced the backlog of outstanding discharge summaries.
- Ward based training sessions requested to support staff when they are unable to attend training.
- Environmental Infection Prevention and Control audits demonstrate improvements.
- Equipment labelling is improving.
- Hand hygiene audit compliance improving but recognise more focussed support is needed in some areas.
- Matrons visited University Hospital Southampton (UHS) and reviewed documentation.
- 1:1s held with registered nurses.
- Effective Baywatch presentation process on wards.
- 15 Steps implementation on wards.
- Medicines reconciliation.
- ENT daycase rate as evidenced by the Getting It Right First Time (GIRFT) review.
- Diagnostics as evidenced by Getting It Right First Time (GIRFT) review.
- Cellular Pathology outstanding accreditation.
- Introduction of call for concern role within the Critical Care Outreach Service.
- National Ophthalmology results demonstrating the Trust's complications rates are amongst the lowest of the 88 centres.
- HSMR is well below the expected range as identified by the Dr Foster February 2019 report.

- Positive outlier for the SMR and HSMR in its regional peer comparator group.
- Outpatient colposcopy rate as identified by Getting It Right First Time (GIRFT) review.

Experience

- John's campaign to support carers of those with dementia.
- Availability of a put up bed for those who need to stay overnight.
- Introduction of a dementia memory room, creating an environment that feels more safe and secure as an inpatient.
- Dementia dedicated champions across departments.
- We are part of the Dementia Awareness Partnership Isle of Wight, overall vision and strategy for the Island incorporates all partners, Clinical Commissioning Group, Isle of Wight NHS Trust, Nursing and Residential Homes, Council and Voluntary sector.
- Introduction of dementia friendly bus stops on the acute medical wards.
- Patient feedback via MES demonstrates good care and compassionate staff.
- Carers lounge supported by Carers IW now on site.
- Freedom to speak up and anti-bullying advisors in place.
- Increase in size of paediatric high care room to allow potential for overnight stays.
- Change in maternity environment to create a welcoming and less overly clinical environment.
- Eye care have a liaison officer embedded in ophthalmology.

Effective

- We are at 100% of NICE baseline tools completed within 3 months timescale.
- Significant improvement on national re-audits – e.g. NELA, Adult and Paediatric Diabetes, Hip Fractures, Lung Cancer.
- Data is being provided for all National Audits where we provide the service.
- 100% compliant with NCEPOD returns.
- SHMI has reduced to 1.01% and our expected deaths at both weekend and weekdays are significantly lower than expected.
- Excellent Clinical Nurse Specialist input into the lung cancer pathway.
- As recognised by GIRFT one of the highest outpatient hysteroscopy rates nationally.
- Introduction of pathway navigators to the acute wards to support discharge planning and communication with patients and relatives around their discharge plans.

We will continue to:

- Maintain mandatory training which is reviewed monthly;
- Increase senior nurse presence on the wards to monitor standards of documentation and Infection Prevention and Control compliance;
- Review and revision of existing documentation;
- Care Group to continue monitoring and addressing Staffing challenges with support of Human Resources;
- Working differently with Development and Training to ensure an educated and competent workforce.

Ambulance

Ambulance Service

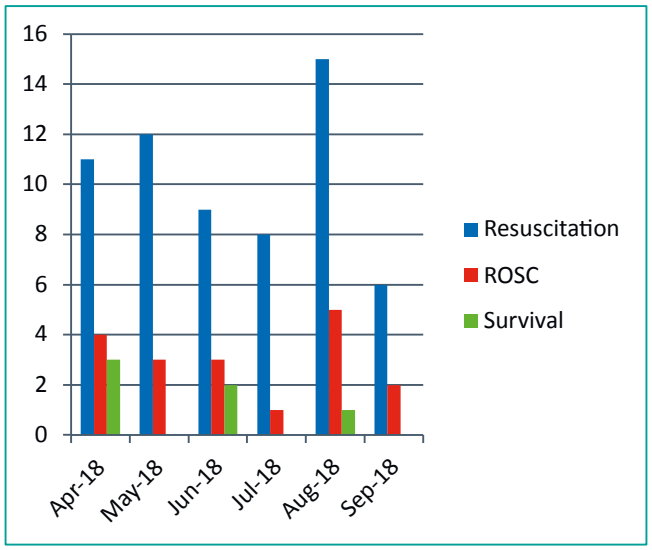
Ambulance Quality Indicators (AQIS) are ambulance specific and are concerned with patient safety and outcomes. They are designed to be consistent with measures in other parts of the NHS, most notably those from emergency departments. They comprise the System Indicators and the Clinical Outcomes.

- Outcome from cardiac arrest – Return of spontaneous circulation.
- Outcome from cardiac arrest – Survival to discharge.
- Outcome from stroke for ambulance patients.
- Outcome from acute ST-elevation myocardial infarction (STEMI).
- Ambulance Response Programme compliance against national standards.

Cardiac Arrest

Each indicator is calculated based on clinically relevant times, delivery of relevant clinical care criteria and/or patient outcomes. They are reported four months retrospectively so current data is complete until September/October 2018.

Shown in the graph below are the Isle of Wight Ambulance Service data sets relating to patients who have suffered a cardiac arrest in the community. 'ROSC' is a recording of whether the patient had a Return of Spontaneous Circulation (their heart started beating again) and survival to discharge is the number of patients who were still alive and discharged from hospital 30 days after their cardiac arrest event.

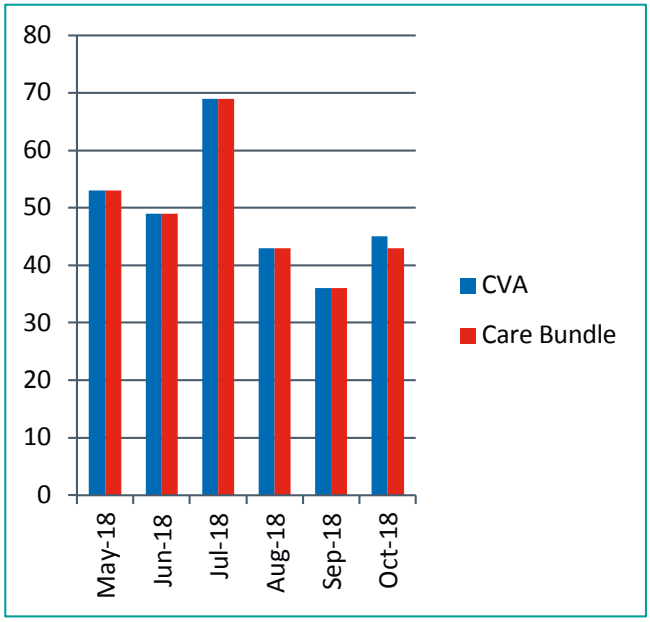


	Ambulance Resuscitation	ROSC on hospital arrival	Discharged from hospital alive
Apr–18	11	4	3
May–18	12	3	0
Jun–18	9	3	2
Jul–18	8	1	0
Aug–18	15	5	1
Sep–18	6	2	0

As the numbers of patients treated by the ambulance service on the Isle of Wight are low compared to the larger services with bigger populations, the data interpretation is difficult as only a relatively minor change in the numbers can have a significant impact on the percentages. There are many factors which can influence a patient's likelihood of achieving a heartbeat again after having a cardiac arrest in the community such as whether bystander resuscitation (CPR) attempts were made and the underlying reason for the cardiac arrest initially. These figures show that the Isle of Wight ambulance service achieves a return of circulation for patients who have suffered an out of hospital cardiac arrest broadly in line with mainland service figures, but ours are more prone to large variations due to small numbers rather than significant improvements or drops in clinical care delivery.

Stroke

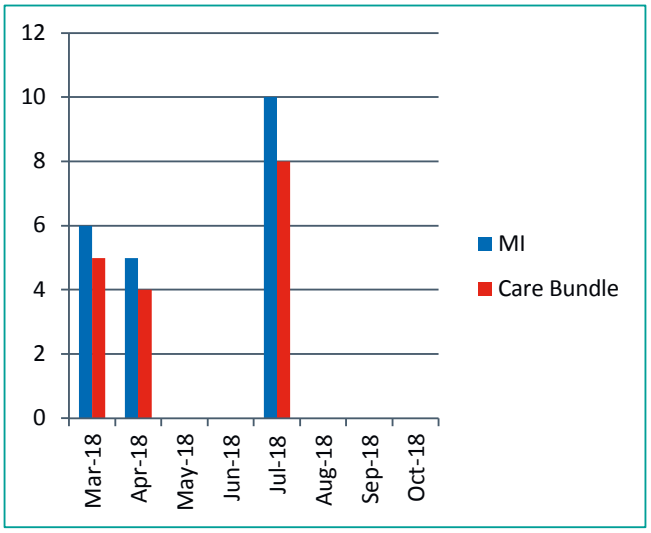
Another measure looked at is the care bundle delivered to patients suffering a suspected stroke or 'CVA'. A 'care bundle' is a set of clinical measurements or interventions that if completed, have been shown to improve patient outcomes. The Isle of Wight Ambulance Service regularly records over 95% compliance in care bundle delivery for patients identified as having potentially suffered a CVA and is regularly in the top performing services for delivering this particular care.



	Suspected CVA assessed face to face	Suspected CVA with care bundle
May–18	53	53
Jun–18	49	49
Jul–18	69	69
Aug–18	43	43
Sep–18	36	36
Oct–18	45	43

Myocardial Infarction (MI)

Patients suffering a particular type of heart attack require delivery of a care bundle to help improve outcomes. The Isle of Wight NHS Trust has very low numbers of patients monthly who fit the criteria so it is very difficult to extract meaningful data for the figures. The care bundle includes recording of certain observations such as pain scores and delivery of pain relief.



	Diagnosis of STEMI from Echo Cardio Graph (ECG)	Suspected STEMI care bundle
Mar–18	6	5
Apr–18	5	4
May–18	Not required to report	
Jun–18	Not required to report	
Jul–18	10	8
Aug–18	Not required to report	
Sep–18	Not required to report	
Oct–18	0	0

Much like our return of spontaneous circulation figures, the Isle of Wight attended a low number of patients per month compared to the larger mainland services, which makes meaningful comparison against their statistics very difficult. For example, if a crew did not complete documentation to explain that a patient was unable to give a pain score because they fell unconscious then they would fail the care bundle delivery. If the ambulance service only attend five patients who fit this category in a month, that single documentation error will drop our care bundle compliance by 20%. Despite these limitations these figures demonstrate a generally high compliance to care bundle delivery and the low numbers also allow our clinical support officers to be able to scrutinise every relevant call to identify if any individual or service learning can be applied to help improve our figures overall.

Ambulance Response Programme

The Isle of Wight Ambulance Service report against the national Ambulance Response Programme (ARP). The purpose of ARP is to ensure the most appropriate response to the patient.

Response Category	Mean standard	90% standard
Category 1	7 Minutes	15 minutes
Category 2	18 minutes	40 minutes
Category 3		120 minutes
Category 4		180 minutes

NHS111 service

111 / Integrated Urgent Care (IUC) Performance	Standard	Performance
Call Answer	95% <60 seconds	93.98%
Calls abandoned	<5% after 30 seconds	2.82%
111 clinician input	>20%	27.11%
IUC (CAS) clinician – calls triaged	>50%	53.93%

The NHS111 performance standards demonstrate the continued position of good call handling standards, with improving clinical standards. The overall performance of the NHS111 service on the island continues to be excellent with consistently less 111 calls resulting in an ambulance disposition better than the national average.

Isle of Wight Ambulance Service (IWAS) ARP Performance 1st – 21st March 2019

Category 1

Incidents	85
Mean Response Time	09:54
Response @ 90th Percentile	19:14

Category 2

Incidents	831
Mean Response Time	19:11
Response @ 90th Percentile	0:39:16

Category 4

Incidents	80
Mean Response Time	1:29:51
Response @ 90th Percentile	3:37:19

Outcome

H & T	134
S & T	585
S, T & C ED Only	1,178
S, T & C Non-ED	38

Category 1T

Incidents	53
Mean Response Time	13:10
Response @ 90th Percentile	22:48

Category 3

Incidents	684
Mean Response Time	0:53:00
Response @ 90th Percentile	2:02:58

The above data shows which standards the IWAS is currently meeting. The service has been reporting on the ARP standards since October 2018 and has shown a general improvement in this time period.

2018/19 Review of Performance against patient safety, quality and effectiveness

Over the last year, patient safety has been a focus for the ambulance service and the implementation of the new Computer Aided Dispatch (CAD) has greatly enhanced the service's ability to report effectively against the ambulance response programme standards. It has also allowed for real time assessment of service demand and will help inform workforce and rota planning for the coming year. This has allowed improved responsiveness to patients by allowing a more directed approach of ensuring the right clinician is sent to respond to each individual patient's needs.

- The Ambulance Service use this data to review all category 1 and 2 patients who have had a long wait (the response took over the standard average time) to look for any patient harm or poor patient experience.
- The service reviews every ambulance re-attendance to a patient within 24 hours to clinically review whether the initial non conveyance was clinically safe or whether there was potential for patient harm.
- The ambulance service undertakes mortality reviews on all patients who have a cardiac arrest whilst in our care, so this includes from the point of calling for help via either 111 or 999 until the patient is handed over in ED.

The ambulance service focuses the key themes of education of its staff on learning from complaints and incidents (local and national) as well as listening and acting on what staff would like to see included within their training plans.

Quality Strategies

The ambulance service has specific strategies for:

- Quality.
- Patient Engagement.
- Staff Engagement.

The Ambulance Quality Strategy identifies the ambulance service priorities for 2018 to 2020. Key priorities include sepsis identification and treatment and the embedding of NEWS2 scoring to help clinicians identify a patient who is deteriorating.

The ambulance service is one of the only services whose paramedics deliver pre hospital antibiotics for sepsis. Working closely with microbiology the antibiotic used has been changed from piperacillin tazobactum to co-amoxiclav in line with current practice recommendations. A new screen and treat tool to identify sepsis in the community was implemented after having been designed by both officers and ambulance frontline staff.

The Ambulance Patient Engagement strategy was the vehicle to help support an extensive piece of work to help better inform and engage with members of the public from a wide variety of backgrounds. Over 80 contacts were made resulting in over 16 public engagement events. Feedback was collected from these events and an action plan developed to address any concerns raised or to deal with any further requests for information.

The ambulance service had a vehicle as part of the PRIDE parade, and next year the plan is to increase the ambulance service visibility at a number of key public events across the island such as the Garlic festival.

The Ambulance Staff Engagement strategy was designed to improve engagement with staff and to increase their involvement in service development. Part of the coming year training plan is Quality Improvement training and staff can apply under the staff engagement strategy for time stood down from front line duties to undertake quality improvement projects with a focus on improving either staff or patient experience.

Staff feedback is regularly sought in a number of areas such as equipment trials and staff morale. A recent local survey sent to ambulance staff indicated that approximately 70% felt that the ambulance service across all areas should be rated as either good or outstanding for well led. Recent staff welfare developments include body worn video cameras to help support court cases against members of the public who are abusive towards ambulance staff, and a number of staff have been specially trained to provide peer to peer support after traumatic call outs for both frontline operations and control room staff. There is an officer available for face to face support 24 hours a day and a control and command structure of an operational and tactical commander either on site or on call 24 hours a day for incident management and staff welfare.

The ambulance service continues to develop its community practitioner group, who are registered on the Southampton University Advanced Practitioner pathway, undertaking Masters level modules in subjects such as history taking and physical assessment and clinical decision making. The community practitioners work alongside ambulance, ED and urgent care providing a high level of clinical assessment and treatment both in the community and within the acute trust setting. The availability of the community practitioner allows the Ambulance Service to broaden the options of type of response to send to the differing category of patients to ensure the most appropriate skill set for the patient needs. Currently the ambulance service are supporting a number of students through the paramedic science university courses to help support a sustainable workforce for the future.

Community Division

Community Services

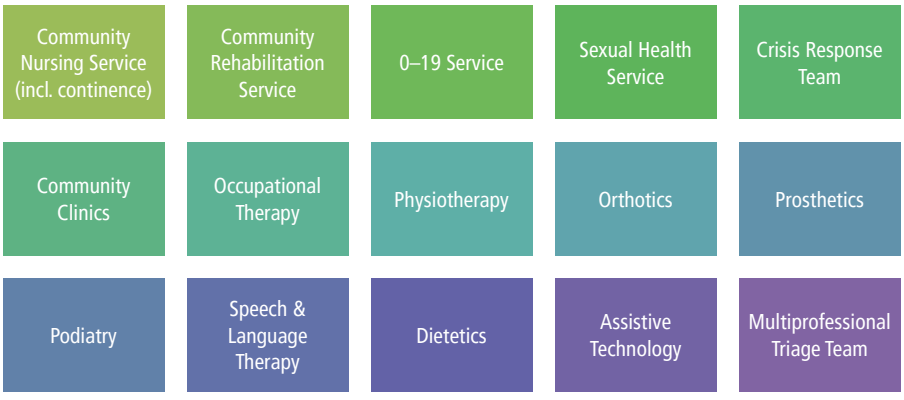
2018/19 Review of Performance against patient safety, quality and effectiveness

The Community Division is still fairly new in its current structure, several changes have been made at a senior level and there are new people in post, although there are still several posts that are interim. The Division's goal is to ensure people receive best practice care at the point of delivery and that no person is admitted to an acute setting unless this is unavoidable.

We will achieve this through:

- Continuous improvement of Community Divisional services to enhance the experiences and outcomes for the Island population.
- Implementing creative solutions to allow funding to follow the person to sustain enhanced community services.
- Enhancing the use of technology across the division.
- Focusing on prevention and early intervention, including building people's own resilience and support networks.
- Wrapping services around the person to support their needs.
- Improved partnership working with primary care and voluntary and independent sector partners.

The services we provide are:



Over the last year, patient safety has been a focus for the Division and the governance structure bears little resemblance to the last CQC inspection; there is a formulated process for reporting, monitoring and challenging performance with an escalation process that progresses through to Trust Board. We have a Quality Manager in post who co-ordinates, monitors and builds reports for the Division, whilst supporting Team/Service Leads with bespoke focused work that supports and aids them with investigations.

From a service perspective, all staff have had access to incident management training, managers have had more bespoke education in the investigation and handling of those incidents and there has also been focus on risk management. The reporting mechanism in this system has allowed us to monitor trends and undertake deep dives in areas of concern.

Integrated Localities

The Division is also working on improving service delivery through Integrated Localities, a collaborative approach to care and support governed through an Alliance Commissioning Framework. Providers from the Trust, Adult Social Services and Age UK work in partnership with Primary Care, Police, Fire, Pharmacy, Housing and Town and Parish Councils to:

Improve co-ordination of care:

- Prevent crisis situations currently picked up and managed by Primary Health and Adult Social Care.
- Reduce avoidable non-elective hospital admissions & Emergency Department attendances.
- Reduce avoidable Residential and Nursing Care placements.
- Reduce the need for long term intervention from statutory services.
- Avoid duplication of effort across services to create additional capacity.

Example of recent case outlined below:

People's stories

Situation	Lives alone, concerns raised by RSPCA as not managing to look after self or animals, environmental issues, house in state of disrepair.
Obstacles & Challenges	Legal issues due to joint ownership of property. Housing grant eligibility not met.
Action	ILS intervention: Care Navigator in place. Court of protection applied for. Benefits application made.
Result	Legal issues resolved. Due to new benefit claim now eligible to apply for grant funding which was successful. Property is becoming more manageable and liveable. Person is managing well and feels house proud.

March 2019

Quality Improvement

Quality Improvement has been applied and embedded across the Division, each service has a rolling ten week improvement plan which allows them to monitor and sustain key areas, such as mandatory training – whilst allowing them to focus on their own areas of service improvement and support their teams in monitoring progress.

A workforce review is underway as there are several small teams with specialist roles and emphasis given to specific specialist posts, this review will inform our divisional plan going forward. There are also plans to explore the demands on our service, the capacity required to meet the demands and the opportunities for further service/ role development. The overarching aim is to ensure that we are able to address the local workforce demands and meet the aims of the NHS Long Term Plan, the Trust Organisational Development Plan and the needs of the Isle of Wight population working in alliance with external partners:

- Right Staff.
- Right Skills.
- Right Place and Right Time.

Quality Strategy

The Community Quality Strategy identifies how the Division will address the Trust priorities for 2018 to 2020. Key priorities include learning from events/experience, improving clinical standards and embedding NEWS2 scoring to help identify the deteriorating patient.

The Division is in the process of developing a Patient Engagement strategy to help inform and engage with members of the public from a wide variety of backgrounds in a way that is meaningful and inclusive. The strategy will also look at involving patients in accessing technology support, increasing education and support for long term conditions and improving ways of self-management. This approach will encourage providers and patients to work together, increasing involvement in decision making and improved health outcomes.

The Division is also developing a Staff Engagement Strategy, aimed at improving the way in which we engage and communicate with our staff and also increasing staff response rates to staff surveys. We aspire to improve the way that all of our staff rate their engagement with services, leadership, and change processes. This strategy should allow for the development of a more engaged workforce, leading to improved patient care and workplace culture, and supporting our Divisional Goal.

Service Successes and Future Opportunities

0–19 Successes:

- Positive launch School Readiness pilot with key stakeholders.
- Implementation of 'Poo bags' for childhood constipation.

0–19 Opportunities:

- Development and piloting of electronic birth book.
- Mandatory fields introduced on PARIS to enable data collection.
- Electronic and manual Key Performance Indicators (KPIs) compared and areas for change identified.
- IT Training programme for staff to further reduce the use of paper copies developed.

Children's SLT Successes:

- Rolling out Isle Attend, to reception classes and impact on children's outcomes.
- Waiting times well within target (average wait six weeks).
- Mandatory training is at 94% for the team.
- Appraisals at 100%.

Children's SLT Opportunities:

- Developing training packages for staff to support more effective implementation of advice.
- Developing parent intervention/coaching groups to support implementation of advice.

What is the National Child Measurement Programme?

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged four to five) and year six (aged ten to eleven), to assess overweight and obesity levels in children within primary schools.

- Working in conjunction with the Local Augmentative and Alternative Communication (LAACES) project which provides tertiary specialist provider ACE Centre to support access to AAC for the Isle of Wight population.
- Will be aiming for a Makaton Friendly badge for Isle of Wight NHS Trust (use of AAC in the hospital), starting with admissions and children's ward.

Community Clinics Successes:

- Due to continued monitoring of room usage there has been improved utilisation of the resources.

Community Clinics Opportunities:

- Paper lite systems.

Community Nursing Successes:

- Leg Ulcer training ongoing – managing to prioritise even at the busiest of times.
- New diabetic care plan written and being rolled out.
- Mortality reviews embedded into practice – robust reviews happening.
- Pressure Ulcer Competency being completed in all teams.

Community Nursing Opportunities:

- Given 40K to enable a review of diabetes care.
- Lessons learnt framework embedded.
- Continue to trouble shoot SystmOne issues but risk decreasing as staff getting more used to the device.
- Demand & capacity ongoing review.

Community Rehab Successes:

- Allocation huddles for Community Team.
- Recruitment to posts (Band 7 Physio, Nurse, Band 6 Occupational Therapist, Band 3 and Band 2 positions).
- Developing data capture and activity recording for Service.

Community Rehab Opportunities:

- Relocation of Office Space.
- Alignment and Recruitment of Reablement therapies.
- Closer working with Crisis/Rapid Access to Community Response (RACR) Services.
- Single Point of Access (SPA) for Rehab and Reablement beds.
- Use of PCS for Beds to align clinical notes and care plans
- Project to look at facilitating discharge to beds via in reach and take home approach.

Crisis Response Successes:

- Manage to secure temporary equipment from Ambulance service and older device from medical electronics.
- Reduced unnecessary hospital admissions reducing Trust and Local authority spending.
- More streamlined integration with all community services and MDT, This is such a demonstration of Multi-Disciplinary Team (MDT) working.
- Changing mindset of health and social care workers in abilities to maintain people at home.

Crisis Response Opportunities:

- Rapid Access to Crisis Response (RACR).

Dietetics Successes:

- Positive patient outcomes from the very low Kcal/Newcastle diet with patients achieving 15kg weightless, improved HBA1C and reduction in diabetes medication.
- Prompt responsive service to those referred to the allergy unit with Cow's Milk Protein Allergy (CMPA), with dietetic intervention and treatment prior to consultant appointment – feedback is positive "thank you for your help and support I have a different baby who is now happy and settled'.

Dietetics Opportunities:

- Community dietitian now in post which is a joint post with Medicine Optimisation team therefore opportunities to promote effective prescribing of nutritional products, promote nutritional screening and treating malnutrition.
- Nutritional education sessions now planned for the next six months covering community, acute and paediatrics.

Falls Prevention Service Successes:

- 15 staff members across the Trust qualified as Chair Based Exercise Leaders early March 2019.
- Five Physiotherapy staff have completed Level one Vestibular Rehabilitation training.
- Feedback received complimenting the professionalism and effectiveness of two of our Postural Stability Instructors.

- Quality improvement project starting in the community rehabilitation beds to improve the screening of visual impairment as part of multi-factorial falls risk assessment.

Falls Prevention Service Opportunities:

- Single electronic falls risk assessment being reviewed and adapted in conjunction with Hartford Care for patients in a community rehabilitation bed.
- Can teams start to identify a member of staff who has a particular interest in falls prevention to work alongside falls leads as part of improving compliance with evidence based practice.

Orthotics & Prosthetics Successes:

- Provision of second C-fibre KAFO providing improved stability and reduced weight for patients with long term musculoskeletal dysfunction e.g. patients with Multiple Sclerosis, Polio etc.
- Provision of first adjustable prosthetic socket utilising BOA technology achieving 10/10 socket comfort score.
- Productivity improvements in procurement and administrative processes using 'Productive' improvement methods.
- "Staff were so helpful, cheery and so happy to improve my life and walking problems. Anne was marvellous. Five Star service and so happy".

Orthotics & Prosthetics Opportunities:

- Involvement in Orthotic Improvement Collaborative (NHSE/NHSI).
- Pilot site for proposed NHSE Prosthetic data collection as part of national Prosthetic Review.
- Apprenticeships for Level six Prosthetist/Orthoptist and L3 Prosthetic/Orthotic Technician.
- Participation in International Society of Prosthetics and Orthotics Socket Technology Workshop.
- Training site for Year two degree student.

Occupational Therapy Successes:

- Acute Team: Appraisal rate:100%, Mandatory training: 92%.
- Stroke Team now sit within the Acute for management support to enable a whole service view to assist with covering any shortfalls and freeing up more clinical time for Stroke Specialist.
- Paediatric team: More joint approaches to working and working towards a whole Therapy approach.
- Very positive working with Schools.

Occupational Therapy Opportunities:

- Team has been reconfigured to provide for an ASD team with allocated staffing and a Physical Health team with allocated staffing.
- Planning in progress to look at all pathways across the service to ensure that up to date information and resources are utilised. More joint work planned with other Therapy teams.
- Planning in place to provide the necessary objectives requested by the CCG. Special Education Needs Co-Ordinator (SENCO) training and workshops.
- More community working and looking at community opportunities. E.g. Community venues such as the Island riding centre and Gym.
- For the future: looking at how OT can support Community and Acute services e.g. GP practices and Ambulance service. MDT Locality working, Falls, seven day working.

Physiotherapy Successes:

- First Point of Contact Msk Advanced Practitioner in GP Practices – service starting 25th February for a period of one year initially.
- Occ Health CQUIN two year pilot 0.50 WTE B7 physiotherapist – rapid access for all Trust staff with MSK conditions. Significant reduction in MSK related sick days. Confirmation of funding for 2nd year.
- Letter in County Press complimenting PSI group staff.
- MSK Physio – "Excellent".
- "It has made such a difference in my day to day life and work", "I am so grateful to my physiotherapist – he was brilliant".

Physiotherapy Opportunities:

- Income Generation Opportunities for example private GP Msk First Point of Contact (FPC), Pelvic, obstetrics and gynaecology Physiotherapist (POGP), Stroke/Rehab, Respiratory, Neurology, Paediatrics and Cardiac Physiotherapy offered via Mottistone.
- Income Generation – classes held at Isle of Wight College gym.
- Advanced practitioner roles in Acute, Orthopaedics, community rehabilitation, paediatrics, chronic pain and outpatient respiratory.
- Participate in research: approx. £620 per month income.
- Occupational Health Msk Service provision for Isle of Wight businesses.

Podiatry Successes:

- Compliments on Datix for podiatry.
- Diabetes foot guidelines ratified and being escalated especially to ED.

Podiatry Opportunities:

- TEC collaboration being explored for rapid access for high risk ulceration/vascular issues.
- GIRFT review due end April to look at Diabetes services – good opportunity to highlight improvements in Foot services.

Sexual Health Service Successes:

- Two year contract negotiated.
- Robust Syphilis outbreak action plan – no new cases.
- 100% patients would highly recommend service.
- Achieved £54k CIP and £107k income to date.
- Research into Point of Care testing collaboration agreement signed.

Sexual Health Opportunities:

- Work with commissioners over two years around service transformation.
- Point of Care Testing to commence April/May 2019.
- BASHH Audit around 'testing to result to treatment highlighted concerns around turnaround of lab results – opportunity to change providers?
- Standards for on line testing enable a more robust triage system meaning targeted testing.

Adult SLT Successes:

- Tele Swallowing Project.
- MDT MND Clinic.
- Weekly Huddle with team.
- CPD Sessions.
- Waiting list management.
- Ongoing successful working relationship with ACE Centre.

Adult SLT Opportunities:

- Tele swallow – train the trainer – SLT team able to lead the roll out of this.
- LAACES – Whole System (Island wide) SLT approach to AAC.

Community SMT Successes:

- Feedback from finance positive around divisions grip on finances, now achieved our control total.
- Safety Matters presentation.
- Representation from Community – 0–19 and ILS at Quality Marketplace.
- Continued development of division governance.

Community SMT Opportunities:

- Work started with Primary Care on Primary Care Networks. Opportunity to develop further integrated services.
- Staff and Service user engagement strategy being developed. Will bring to future meeting.
- TEC providing Community Services with solutions that improve patient safety, efficiencies and boost staff morale, e.g. Tele-swallowing, podiatry mapping.
- SCIE workshop on 26/03/19 to facilitate collaborative approach to establish Integrated Complex Discharge Team.

TEC Successes:

- Telehealth training completed to the care homes in Sandown.
- Train the trainer training to commence week commencing 19th March.
- Shortlisted for new TEC Apprentice.

TEC Opportunities:

- Hub integration.
- Video consultation.

Mental Health Division

Mental Health Services

2018/19 Review of Performance against patient safety, quality and effectiveness

In the past year the Mental Health and Learning Disability Division has focussed on improving the quality of services, and on working with people who use services, staff and other partners to transform pathways of care. Through engagement with people who use services, staff, and other partners we have co-produced a vision and principles for mental health and learning disability services:

'We will create and deliver an integrated, seamless and person-centred mental health and learning disability service for the Isle of Wight that means people have their needs met in the right way and at the right time.'

A number of principles have been developed that apply to all parts of the service:

People with lived experience of mental ill health, and people with a learning disability will be equal partners in everything we do including the delivery, commissioning, design and governance of our services. We will:

- Work to empower people to have hopeful, meaningful and purposeful lives through developing self-esteem, identity and self-worth;
- Work in collaboration with our partners to deliver a seamless and integrated service;
- Build trust through open, honest and respectful relationships with people who use services, people who work in them and other partners;
- Ensure services are easy to access and welcoming to those who use them;
- Create a caring and compassionate environment for the people who use our services, and the people who work in them;
- Deliver safe, responsive and consistently high quality service.

Priorities for Improving Our Services

The key priorities have been:

- Governance – we have established robust governance systems that extend from all teams through to the Division, and into the Trust. This enables us to escalate concerns rapidly and effectively.
- 'Getting to Good' – we have focussed on addressing the concerns identified by the CQC, with transformation work in the Community Mental Health service, Single Point of Access and Shackleton ward.
- Transformation of Services – working in partnership with staff and people who use services to design and deliver robust, evidence-based patient centred care pathways that enable people to achieve improved clinical and social outcomes.
- Improving experience of people who use services – we are engaging with people who use services to understand their experience of receiving care, and enable them to work with us to make the improvements required. This engagement is facilitated by the recruitment of three service user involvement co-ordinators, who are working alongside our leadership team to support all aspects of Divisional business.
- Improving staff experience – we have engaged with staff in a range of ways, supported by a staff engagement forum, to understand and improve their experience of work in the service, and enable them to make the improvements required.

The Mental Health and Learning Disabilities Quality Strategy

The Mental Health and Learning Disabilities Division has developed a Quality Strategy which aligns with the wider Trust strategy and ensures that the improvements planned are specific to Mental Health and Learning Disabilities service users and their families. Setting and achievement of milestones and outcomes is monitored through the Quality Improvement Board. The diagram below describes the quality strategy priorities:

SAFE: learning from events	SAFE: preventing suicide	SAFE: reducing death from physical illness
EFFECTIVE: right person, right place, right time	EFFECTIVE: best clinical and social outcomes	
EXPERIENCE: learning from experience	EXPERIENCE: end of life care	EXPERIENCE: dementia care

Progress against priorities:

Safe

- The SI process has been improved with more robust check and challenge of reports. This includes oversight by the Mental Health and Learning Disability Executive Director and the Corporate Quality Governance Team.
- Additional training organised for Root Cause Analysis to ensure that the Division have enough staff able to lead investigations.
- Over the past twelve months there has been an improvement in the timeliness of SI and Complaint investigations and a large decrease in the number of investigations becoming overdue, this has had a positive impact on the ability of the service to respond in a timely way to any changes required.
- All actions arising from investigations are now added to the relevant DATIX incident form, this allows for robust monitoring of actions being completed.
- Risk assessment templates are now routinely used within Single Point of Access (SPA).
- The Division is currently working with the Performance Information Team to improve reporting of trends to allow thematic analysis of incidents, this is enabling services to identify and act on relevant issues.

Effective

- There has been marked improvement in waiting times within the Single Point of Access (SPA). The team have reduced Referral To Treatment (RTT) for both urgent and routine referrals to the service which will ensure that service users with increased risks are seen and assessed within appropriate timescales. Historically urgent referrals were waiting weeks to be seen, initial contact is now made within 24hrs and face to face assessments offered within 72 hours. Timescales for routine referrals have also reduced in line with national benchmarking.
- A change to the medical staffing cover for both acute and SPA teams has resulted in more robust MDT working.
- The Division has commenced working with Northumberland Tyne and Wear Foundation Trust and as part of this work is undertaking training needs analysis and workforce planning across the Division.
- The Division now has an identified link manager within Human Resources to ensure that recruitment and retention issues are given priority.

- The Early Intervention in Psychosis (EIP) team have moved to a new team base off hospital site which will enable fuller community integration. The building is able to facilitate group works with their client group which was not possible in the old base.
- The Wellbeing Team has commenced work to identify those on community caseloads that need alternative provision or intervention. The team have also commenced working with those people moving off care co-ordinators case loads to provide interventions which address biopsychosocial needs.
- Clinical pathways have been produced through MDT work shops, further workforce planning will ensure that the right staff, with the right skills, are in place to deliver the required interventions.
- The Recovery Star is being piloted within the service.

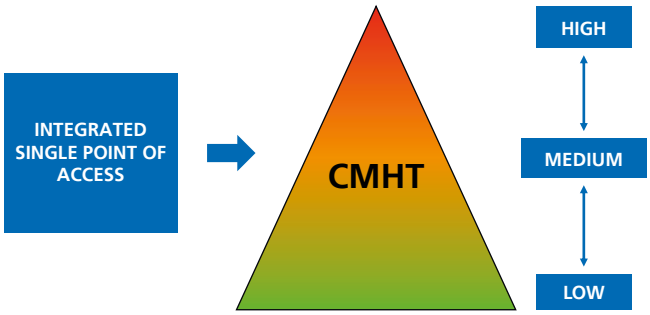
Experience

- There are improved systems for documenting service user and family/carer feedback. Information and guidance has been circulated to all staff in the Division and there is some evidence that this is now being recorded more effectively. This is going to be available at team level on the newly developed dashboard.
- The Division has developed and recruited to three Service User and Family Co-ordinator posts which will increase the focus on providing co-produced services.
- End of Life link nurses have been identified in the older persons inpatient wards, and the Division has worked with the End of Life lead for the Trust to ensure that there are audit tools in place appropriate to mental health services.
- Staff within Older persons services have undertaken 'train the trainer' training in the Gemma Jones model and are in the process of rolling this out to all staff working on Shackleton Ward.

Quality Improvements in Mental Health and Learning Disability Services

Community Mental Health Services (CMHS)

The CMHS is currently implementing a new model of care that has been developed in consultation with people who use the service, staff and other partners. This includes the establishment of a new service – the mental health wellbeing service, which supports people in their recovery from mental ill health, and in future will be delivered by a third sector partner. The changes will enable the CMHS to be more accessible and responsive to the needs of people using the service. We have been supported in this work by the Transformation team from Northumbria Tyne and Wear NHS Foundation Trust, an outstanding mental health trust.



In preparation for the transformation of these services there have been a number of quality improvements, including:

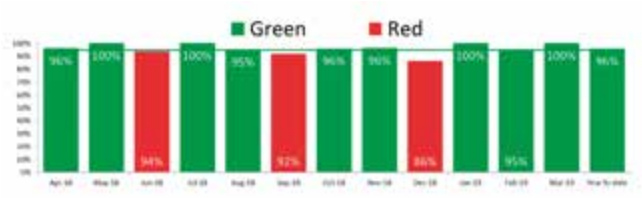
- Strengthened caseload supervision structures in place.
- Medical model changes – reduced consultant caseloads, and increased medical input to the Single Point of Access (SPA).
- Significant improvements in the referral to assessment time in SPA.
- Introduction of the Flexible Assertive Community Team (FACT) model to improve responsiveness to highest risk service users.
- Development and use of a standardised risk assessment template in SPA.

Acute Mental Health Services

Acute mental health services include inpatient and community based services for people with acute mental illness, including the Home treatment team, Osborne and Seagrove wards, and the liaison service.

Seagrove ward is participating in the Royal College of Psychiatrists restrictive intervention programme, with a focus on reducing the using of restraint and seclusion, using quality improvement methodologies.

Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care.



Percentage of admissions to acute wards for which the Home Treatment Team acted as gatekeeper.

Quality improvements in the acute service this year include:

- Reduction in acute beds from 27 to 22.
- Improved inpatient environment, including refurbishment of the Psychiatric Intensive Care Unit seclusion room.
- Reduced use of restraint and seclusion.
- Changed medical model to improve continuity of care and increase Home Treatment medical support.

Older People's Mental Health Services

Older People's Mental Health services are for older people aged 65 and over, although there is no upper age limit in CMHS, so some older patients access mental health services in CMHS. Services include the memory clinic, Shackleton and Afton wards and the dementia liaison service.

Shackleton has been a significant focus for quality improvement this year with work to strengthen the clinical model and reduce the use of restrictive practice.

Quality improvements in the acute service this year include:

- Reduction in use of seclusion and rapid tranquillisation.
- Reduction in older persons beds from 19 to 14.
- Planning for a major refurbishment of the environment in Shackleton ward, to begin in April 2019.

Recovery, Rehabilitation and Reablement services

The Recovery, rehabilitation and reablement service delivers inpatient and community services for people with severe mental health problems who require support to re-learn skills to live independently.

Quality improvements in these services include:

- Reduction in the number of people in off-island rehab placements.

Community Child and Adolescent Mental Health Services

The Child and Adolescent Mental Health Service delivers community mental health services to children and young people up to the age of 18 years.

Community Learning Disability Services

In addition to the community learning disability team this service provides an Attention Deficit and Hyperactivity Disorder assessment and prescribing service for adults and an Autism Spectrum Disorder assessment service for adults.

Part Four

Annex

This section includes:

- Statements on the content of the Quality Account from our Stakeholders
- Trust response to stakeholders' statements
- Statement of Directors responsibility
- Statement of assurance from the Independent Auditors
- Abbreviations
- Changes made to the Quality Accounts
- Information on how to provide feedback to the Trust on the Quality Account

Annex 1

Statements on the content of the Quality Accounts from our Key Stakeholders

The Trust is required to send a copy of its Quality Account to the following organisations for their comments:

- NHS England and relevant Clinical Commissioning Group (CCG) (where 50 per cent or more of the relevant health services that the Trust provides are provided under agreements with NHS England, the Trust should send its Quality Account to NHS England, otherwise to the relevant CCG);
- The appropriate Local Healthwatch organisation; and
- The appropriate Overview and Scrutiny Committee (OSC).

The first draft of the Trust's 2018/19 Quality Account was forwarded to key stakeholders on the 24th April 2019 with a request for statements of no more than 500 words to be received before the 24th May 2019. The key stakeholders are:

- NHS England and relevant CCGs – NHS Isle of Wight Clinical Commissioning Group.
- Isle of Wight Council's Policy and Overview Scrutiny Committee (OSC) for Adult Social Care and Health.
- Isle of Wight Healthwatch.
- Patient Council.

As required in the Department of Health guidance, different organisations were requested to comment on specific questions.

The commissioners were asked to:

- Confirm in a statement, to be included in the provider's Quality Account, whether or not they consider the document contains accurate information in relation to services provided and set out any other information they consider relevant to the quality of NHS services provided;
- Take reasonable steps to check the accuracy of data provided in the Quality Account against any data they have been supplied during the year (e.g. as part of a provider's contractual obligations).

The Local Healthwatch and the Overview Policy and Scrutiny Committee were asked to consider:

- Whether the Quality Account is representative.
- Whether this gives comprehensive coverage of the provider's services.
- Whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to the Quality Account.

The statements received can be found overleaf. No amendments have been made to these statements.

Statement by the Councillor John Nicholson, Chairman of the Isle of Wight Council's Policy and Scrutiny Committee for Adult Social Care and Health.

This is my second year as chairman of the Policy and Scrutiny Committee. When looking back over the past twelve months it is pleasing to note the progress being made by the Trust. It has many challenges and, given the limited resources, has shown improvement although the journey to good is at an early stage.

The openness and transparency displayed at Board meetings is to be commended. Additionally members of the public are now able to ask questions at meetings after each section of the agenda. This demonstrates a willingness to listen to the voice of patients.

Although the policy and scrutiny committee only has four formal meetings in a year there is a regular informal dialogue maintained with the Trust. This enables a range of key issues to be debated thereby providing a better understanding of the complexities involved in delivering health care, especially on the Island.

The recent decision of NHS England to place the Trust under special financial measures should be seen as a positive step. This will help demonstrate to NHS England the additional costs of providing a safe and effective level of service that conforms to the requirements of inspecting organisations and national guidelines on an Island.

In reviewing the priorities for 2018/19, and those proposed for 2019/20, these are only the tip of the iceberg. The key focus should be recognising the needs of each individual patient and this should be reflected in any, and all, priorities. Data will only tell one part of the story. The policy and scrutiny committee will continue to utilise patient stories to identify where improvements are required.

One major element not mentioned within the Quality Account is the need to embrace integrated working. This should place the needs of the individual at the centre of service delivery. Whilst discussions are ongoing at a local level there does need to be national recognition of how this could impact upon the resources of each partner. The implementation of the Hampshire and Isle of Wight Sustainability Transformation Partnership with enhanced working arrangements with mainland partners will also impact upon the delivery of priorities. The key issue that is on-going is that of cross Solent transport. This is not only because of the financial implications for patients but the wider physical and mental strain that travel can impose.

At the time of writing the Trust is undergoing a CQC inspection. It is hoped that this will recognise the improvements that are being made. The Committee will continue to support the Trust in the delivery of safe and effective services but will not shy away from raising concerns where these can be evidenced

24th May 2019

NHS

Hampshire and Isle of Wight

Partnership of Clinical Commissioning Groups

Statement by Julia Barton, Executive Director of Quality and Nursing for the Isle of Wight Clinical Commissioning Group in response to the Isle of Wight NHS Trust Quality Account 2018/19.

Thank you for providing the Isle of Wight Clinical Commissioning Group (CCG) with an opportunity to respond to the Trust's quality account for year 2018 / 19.

Following the findings of the CQC inspection in November 2016, and subsequent re-inspection in January 2018, the CCG has worked closely with the Trust and its regulators to ensure robust and effective quality improvement plans were both developed and delivered, in order to realise the significant changes required to ensure that local people receive the consistently high quality of care that they expect and deserve. We have been jointly monitoring and seeking assurance with the regulators via the improvement plan oversight group (QIPOG) and recognise the progress made in 2018/19.

In terms of **regulatory action**, we are aware that the Trust remains in CQC special measures and as a result has remained on the NHS Improvement "challenged providers" list. The CCG has continued to monitor the Trust's extensive CQC improvement plan and the required improvement actions arising from the ongoing application by the CQC of the regulation 31 notice of decision for community mental health services. The CCG recognised and shared the Trust's disappointment when a regulation 29a was issued in early 2019 for urgent and emergency care, following a focussed inspection. The CCG is aware of the extensive range of improvement actions that have been implemented across the emergency pathway since this time, and has been encouraged through the outcome of recent clinical visits, that these actions now seem to be sustained as business as usual across the pathway. The table summarising these actions would benefit from being clearer in terms of what has already been delivered, and what will be delivered this year.

Commissioners are aware that the scale and pace of improvement continues to be significant. The CCG notes that of the three quality priorities that had been identified for 2018 / 19 there has been significant improvements within **end of life care**, which has been fully achieved. Some improvements are also noted within the patient safety priority relating to the **recognition and care of the deteriorating patient**, however commissioners continue to see this as an overarching safety theme arising from serious incidents. Whilst some actions continue the work to improve the detection and treatment of the deteriorating patient are included in the releasing time to care priority for 2019 / 20, we feel this probably warrants a stand-alone priority. We would be delighted to consider a new set of improvement metrics around the management of serious incidents in 2019/20, and would hope this would be supportive in helping the Trust track its progress in this area.

The final 2018/19 quality priority related to clinical effectiveness and delivery of the **'Right Patient, Right Place, Right Time' programme**. This appears to have been more challenging to achieve and commissioners recognise the frequent mismatch of operational capacity and demand, and the impact this has had on patient safety and experience. Commissioners welcome the Trust's intention to continue the work needed on this as a priority in 2019/20.

Commissioners are fully supportive of the trust-wide quality strategy, as well as the divisional quality strategies, all developed in 2018/19. We note these are really supporting the delivery of the quality improvements required and are increasing ownership by the divisions across the integrated Trust.

The CCG is pleased to note that the quality priorities identified for 2019 / 20 have been agreed following consultation with key stakeholders and are derived from the Trust's performance over the past year. These also appear to be aligned with local and national priorities. Commissioners would strongly support quality improvement priorities around the reporting and investigation of patient safety incidents and the spread of learning from these. We have been pleased to support the improvement work around the reporting and investigation of coronial deaths in 2018 / 19, and trust the changes made to internal processes will now yield positive outcomes for the Island.

Commissioners would have welcomed a specific quality priority around patient experience, particularly in the emergency and acute medical pathway, which sees the highest number of complaints and variation in feedback on patient experience.

An area the Trust has identified for improvement internally relates to the collection, analysis and presentation of quality data. Commissioners are aware of a wider trust programme to improve business intelligence, and strongly support actions to improve the use of accurate and reliable quality data to set realistic and achievable improvement targets.

The CCG is pleased to note that the Trust has considered the concern expressed in previous years regarding priorities focusing primarily on acute services and that the priorities agreed for the coming year include community and mental health services. The CCG would be particularly keen to see the priority relating to **dementia** be considered across all services, rather than just acute care and include the specialist dementia mental health in-patient and community aspects of provision.

There is a mixed picture of delivery around national CQUINs, and we are committed to working with the Trust to deliver the 2019/20 CQUIN requirements.

This quality account complies with national guidance and demonstrates areas of achievement as well as areas where improvement is required. The CCG is satisfied that the overall content of the quality account meets the required mandated elements. We have sent you some feedback on presentational matters under separate cover and would support further work on the account to ensure it is accessible to members of the public and patients using Island health services. The CCG would recommend that an 'easy read' version or executive summary is considered.

The CCG is delighted to have continued to work with relevant Trust teams on building strong and constructive relations and on exploring less duplicative and more integrated processes for quality assurance, and look forward to continuing this work in 2019/20. Commissioners value the Trust's open and transparent stance, and the continual invitation for constructive challenge. We are also delighted with the Trust's approach to wider system transformation, and we look forward to continuing this close working relationship with the Trust over the coming year.

Finally, the Isle of Wight CCG can confirm that to the best of their knowledge, the information contained in the report is accurate against that which has been shared with commissioners regarding quality of care.

17th May 2019

healthwatch
Isle of Wight

Healthwatch Isle of Wight Statement by Chris Orchin, Chair in response to the Isle of Wight NHS Trust Quality Account 2018/19.

Healthwatch Isle of Wight has reviewed and considered the Quality Account of the Isle of Wight NHS Trust. It notes that significant work has been undertaken to address the deficiencies identified by the Care Quality Commission during their visit in 2018, however there is still work to be done to ensure all patients receive good quality healthcare when they need it.

It is heartening to note the work being done by the Isle of Wight NHS Trust around compassionate leaders, as compassion should be at the heart of all health care provided both in the hospital setting and in the community. There has also been ongoing work to improve the care of people with sepsis and it is pleasing to note that the Critical Care Outreach team has expanded their sepsis liaison service to cover maternity services and paediatric services.

The newly identified priority of dementia care is appropriate, given the number of people living with this condition on the Island. All people with dementia have the right to be treated compassionately and effectively by trained and knowledgeable staff to ensure that they can live well with the condition. Partnership working with family and carers is essential to ensure that care is seamless and consistent. Following our Enter and View visit in January 2019, extensive refurbishment has improved the environment on Shackleton ward and this will need to be aligned with the development of strong clinical leadership to ensure that people's rights are promoted and maintained.

Quality improvement can best be achieved with partnership working so it is pleasing to see the combining of the hospital End of Life Team and the Mountbatten Palliative Care Team to create a new integrated team, which has already led to an improvement in the experience of patients and families.

It is disappointing to note that overall, of all complaints closed during 2018/19 only 35% of these were within agreed timescales. We know that making a complaint can be extremely difficult for the person and/or their family at a challenging time in their lives so it is essential that concerns and complaints are treated with the highest priority. People need to have confidence in healthcare services and this can only be maintained through compassionate and efficient communication. The learning of complaints should also be cascaded throughout the hospital and community setting to ensure that patient feedback leads to continuous quality improvement.

The development of a new model of care for community mental health services is a positive step, through the development of a mental health Well Being Service and the involvement of the voluntary sector will contribute to the sustainability and quality of the new service. This is a timely response to the disappointing outcomes achieved by current community mental health services. Results of the 2018 Care Quality Commission Community Mental Health survey saw little improvement from the extremely low score generated the year before.

We continue to recognise the commitment and dedication shown by staff at the Isle of Wight NHS Trust, many of whom are working under great pressure, and once again, we would like to extend our gratitude to those people who work tirelessly to care and treat people at their most vulnerable.

27th May 2019

The Patient Council response by Pam Fenna, Chair of the Patient Council to the Quality Account for 2018/2019.

There are many positive achievements reported in the Quality Accounts and the Trust has to be congratulated on these with the enormous amount of hard work undertaken by the staff to make these improvements not underestimated. There are however many areas still requiring significant improvements for all services to reach the high quality levels of care that island residents and its many visitors should be assured of receiving.

It has been clearly demonstrated through the increase in the number of serious incidents that a more open and honest culture has been adopted within the Trust. Work is still required to evidence the learnings gained and changes implemented in practice from these reported incidences. This would provide the Patient Council with assurance and improved confidence of the Trust's commitment to improving services and further demonstrate the culture of openness.

The Trust has stated that the treatment of people suffering from Dementia and their carers are a priority and the need to do this cannot be emphasised enough. The physical environment in St Mary's Hospital is being improved but even with the changes it will be far from ideal so staff training and specialist support will still be a priority both in the special provision and on the general wards.

It is disappointing to note that so few staff engage with the staff survey. It is so important to know how the staff feel because without them and their feelings being appreciated and valued making any sustained improvements in recruitment and the services the staff provide will be almost impossible.

16th May 2019

Trust Response to the Stakeholders' Statements for the Quality Account 2018/2019.

The Trust would like to thank all stakeholders for their comments on the 2018/19 Quality Account. We are pleased that the statements from our stakeholders demonstrate the collaborative commitment we share in improving the quality of services we provide and the outcomes for our patients. It is also pleasing to note that stakeholders are widely in agreement with the patient safety, patient experience and clinical effectiveness improvement priorities selected for 2019/20.

As a result of the formal stakeholder statements and additional comments and suggestions received to further improve the information in the Quality Account, the Trust has made the following amendment since the first draft was sent to the stakeholders:

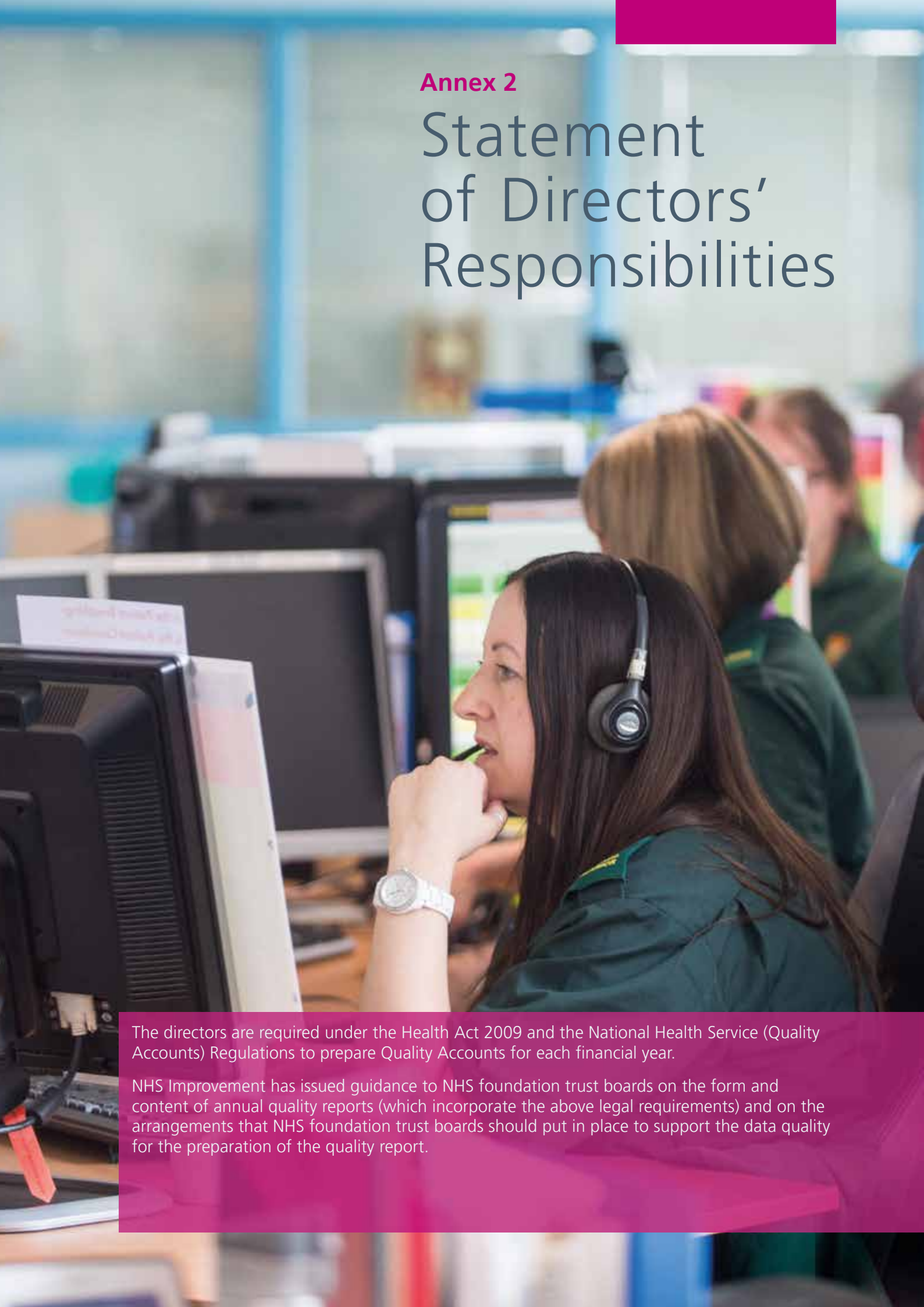
- All the data for the full financial year is now included in the patient safety, clinical effectiveness and patient experience priority updates.

A number of suggestions were also noted from the formal stakeholder statements. The Trust would like to respond to these via this section of the Quality Account.

NHS England and relevant CCGs – NHS Isle of Wight Clinical Commissioning Group.	
The CCG recognised and shared the Trust's disappointment when a regulation 29a was issued in early 2019 for urgent and emergency care, following a focussed inspection. The CCG is aware of the extensive range of improvement actions that have been implemented across the emergency pathway since this time, and has been encouraged through the outcome of recent clinical visits, that these actions now seem to be sustained as business as usual across the pathway. The table summarising these actions would benefit from being clearer in terms of what has already been delivered, and what will be delivered this year.	A more detailed account of the actions taken for improvement has been provided in the table. Following a review of the evidence, this demonstrated compliance that the actions had been completed in all of these areas and therefore RAG rated Green to reflect the correct achievement status. Further progress on improvements on this area of concern can be found on page 103 of this document.
The CCG would be particularly keen to see the priority relating to **dementia** be considered across all services, rather than just acute care and include the specialist dementia mental health in-patient and community aspects of provision.	The Trust identifies that the treatment of people suffering from Dementia and their carers is a priority and the need to do this across all services cannot be emphasised enough. With our population group and the need for partnership working across the Island, further improvements will continue to be made to promote a dementia friendly Island.
Commissioners would have welcomed a specific quality priority around patient experience, particularly in the emergency and acute medical pathway, which sees the highest number of complaints and variation in feedback on patient experience.	The Trust has ensured that all of our priorities for improvement have outcomes measures which are linked to the patient experience. This includes delivery of the **'Right Patient, Right Place, Right Time' programme**.
Isle of Wight Healthwatch	
It is disappointing to note that overall, of all complaints closed during 2018/19 only 35% of these were within agreed timescales. We know that making a complaint can be extremely difficult for the person and/or their family at a challenging time in their lives so it is essential that concerns and complaints are treated with the highest priority. People need to have confidence in healthcare services and this can only be maintained through compassionate and efficient communication. The learning of complaints should also be cascaded throughout the hospital and community setting to ensure that patient feedback leads to continuous quality improvement.	During 2018/19 a significant amount of work has been undertaken to improve the management and learning from complaints. Further improvements on this area of concern can be found on page 70 of this document. The figure of 35% is the full year picture against all Divisions. The year-end position is more reflective of the work undertaken. Both Mental Health and Ambulance achieved the 75% target set, Community narrowly missed this with 71.6% achieved. The Acute division missed this target with a year-end position of 46%. The improvement work linked to the management and learning from complaints will continue during 2019/20 and will be reported in next year's Quality Account.

Annex 2

Statement of Directors' Responsibilities



The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance detailed requirements for Quality Accounts 2018/19.
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period 1st April 2018 to 2nd May 2019;
  - papers relating to quality reported to the board over the period 1st April 2018 to 2nd May 2019;
  - feedback from commissioners dated 17th May 2019;
  - feedback from governors (Patient Council) dated 16th May 2019;
  - feedback from local Healthwatch organisation dated 27th May 2019;
  - feedback from Overview Policy and Scrutiny Committee dated 24th May 2019;
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29th May 2019;
  - the 2017 national inpatient survey 13th June 2018, the 2018 Mental Health Survey 29th November 2018 and 2018 Maternity survey 29th January 2019;
  - the 2018 national staff survey 26th February 2019 for Acute, Ambulance, Community and Mental Health;
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 24th May 2019;
  - CQC inspection report dated 6th June 2018.
- the Quality Account presents a balanced picture of the NHS 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, is subject to appropriate scrutiny and review.
- the Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

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

By order of the board.

Maggie Oldham
Chief Executive Officer

Dated: 24th May 2019

Vaughan Thomas
Chairman

Dated: 24th May 2019

Annex 3

Independent Auditor's Statement of Limited Assurance

Independent auditors' limited assurance report to the directors of Isle of Wight NHS Trust on the annual quality account

This report is produced in accordance with the terms of our engagement letter dated 28th March 2019 for the purpose of reporting to the Directors of Isle of Wight NHS Trust (the 'Trust') in connection with the Quality Account for the year ended 31st March 2019 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 28th March 2019. We permit the disclosure of this report within the Annual Report for the year ended 31st March 2019 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 permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our examination, for this report, or for the opinions we have formed.

Our work has been undertaken so that we might report to the Directors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

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, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017.

Scope and subject matter

The indicators for the year ended 31st March 2019 subject to limited assurance consist of the following indicators:

- Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay; and
- The rate per 100,000 bed days of cases of C. difficile infection that have occurred within the Trust amongst patients aged two or over.

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

Respective responsibilities of Directors and Ernst & Young LLP

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care 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 and Social Care 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 accordance with section 8 of the Health Act 2009 and the criteria set out in the National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014/15 published on the NHS website in March 2015 ("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 the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014/15'. These are:

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from the Commissioners;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, for 2019;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the national patient survey for 2019;
- the latest national staff survey for 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019;
- the annual governance statement dated 24th May 2019;
- the Care Quality Commission's Inspection report dated June 2018; and
- the results of the Clinical Coding Audit dated November 2018.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- 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.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Account. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent 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 and Social Care. 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 31st March 2019:

- 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
Southampton
31st May 2019

Notes:

1. The maintenance and integrity of the Isle of Wight NHS Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the website.
2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Annex 4

Abbreviations and Definitions

AKI

Acute kidney injury.

ANTT

Aseptic Non-Touch Technique

A sterile way of performing invasive procedures such as putting in a cannula or taking blood.

Cannula

A tube that can be inserted into the body, often for the delivery or removal of fluid.

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.

Competencies

Provide a structured guide enabling the identification, evaluation and development of the behaviours in individual employees.

CPA

The Care Programme Approach (CPA)

A way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

CQC

Care Quality Commission

The independent regulator of all health and social care services in England.

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).

EPMA

Electronic Prescribing and Medicines Administrations

EPMA enables prescribers, nurses and pharmacists to efficiently manage, control and monitor the entire drug prescription, administration and recording processes.

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.

GIRFT

Get It Right First Time

Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.

HCAI

Healthcare Associated Infections

Infections that are acquired as a result of healthcare interventions.

HSMR

Hospital Standard Mortality Ratio

HSMR is the ration of observed to expected deaths and a measure of healthcare quality.

iWGC

I Want Great Care

A service which allows NHS and private health care patients to rate individual GPs, hospital doctors and nursing staff on the care they provide.

JAC

An electronic prescribing system.

KPIs

Key Performance Indicators

A way of monitoring and managing performance against a pre-determined target.

LGBT

Lesbian, Gay, Bisexual and Transgender (LGBT)

Intended to emphasise a diversity of sexuality and gender identity-based cultures.

Medical Outlier

A medical patient admitted to a ward anywhere other than a medical ward.

MLAFL

My Life A Full Life

My Life A Full Life is a collaboration of health, care and voluntary sector organisations which has already been working with the community to develop initiatives which enable people to be more in control of their own health, wellbeing and care needs.

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.

MUST

Malnutrition Universal Screening Tool

A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Never Event

Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NEWS

National Early Warning Score

NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

NHS Safety Thermometer

A local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

NICE

National Institute for Health and care Excellence

Provides national guidance and advice to improve health and social care.

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.

PARIS

An electronic patient record system across all of its community and mental health services.

PGD

Patient Group Directions

PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

PHSO

Parliamentary Health Service Ombudsman

Set up by parliament to help both individuals and the public. Their role is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

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

e.g. a cannula for administering intravenous medications and fluids.

Root cause analysis (RCA)

A method of problem solving used for identifying the root causes of faults or problems.

SHMI

The Standardised Hospital-level Mortality Indicator

SHMI is the ratio between actual and expected deaths following hospitalisation. It includes deaths which occurred, inside and outside of hospital, within 30 days of discharge.

SIs

Serious Incidents

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.

Sugar Smart

SUGAR SMART is a campaign run by Jamie Oliver and Sustain which helps local authorities, organisations, workplaces and individuals to reduce the amount of sugar we all consume.

SystmOne

A clinical system which fully supports a ground-breaking vision for a 'one patient, one record' model of healthcare. Using SystmOne, clinicians can access a single source of information, detailing a patient's contact with the health service across a lifetime.

UTI

Urinary Tract Infection

An infection that affects any part of the urinary tract, from kidneys to bladder.

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 a PE.


Dräger
13:02
Discharged
Touch Screen to initiate monitoring
Dräger
Dräger

Annex 5

Changes to the Quality Account

The table opposite provides a summary of changes that were made to the final version of the Quality Account following feedback from stakeholders:

Location	Changes that have been made
Across the quality account	Formatting, print layout, addition of graphics
Across the quality account	Amended data and spelling corrections
Statements by CCG, Healthwatch, OSC and Patient Council	Statements added
Independent Auditor	Statement of Limited Assurance added
Abbreviations and Definitions	Amended and additional abbreviations added
Information Governance Toolkit	Updated report results and narrative

Annex 6

Information on how to provide feedback

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 2019/20 set out in Part two of this Quality Account.

We 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** (listed as 'NHS Isle of Wight Provider Services').


Fire
exit

Isle of Wight NHS Trust provides Ambulance, Community, Corporate, Hospital, Learning Disability & Mental Health services.

www.iow.nhs.uk

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