Quality Account 2012-2013

Introduction

The purpose of this Quality Account is to provide patients, their families and carers, staff, members of the local communities and local commissioners, with a report on the quality of services that the Trust provides.

The Quality Account is one aspect of the continued drive to improve the quality and safety of the services we provide.

In part one, there is a statement on quality from the chief executive, Jacqueline Totterdell. An update is also provided on the priorities that were set by the Trust for 2012/13, and details of the priorities set for the coming year.

In part two, there are a number of statements of assurance regarding specific aspects of service provision. The Trust is required to provide these statements to meet the requirements of the Department of Health and Monitor.

Part three contains further information which provides a picture of some of the other initiatives that have been implemented at the Trust to improve quality, with the latter sections providing some commentaries which express the views of some of the Trust’s key stakeholders.

Thank you for taking the time to read our Quality Account. If you would like to comment on any aspect of this document, we would welcome your feedback.

You can contact us at communications@southend.nhs.uk
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Part 1

Statement on quality from the chief executive

Welcome to our Quality Account 2012/13, which describes just how seriously we consider quality and safety issues in our hospital and how we will work continuously to make improvements where they are needed.

This has been a difficult period for the whole of the NHS and this year in particular, following the publication of the Francis report, the quality of care in hospitals has rightly been in the spotlight. But I also know that the staff here at Southend are as committed and as passionate as I am about putting quality care, and the experience of our patients, central to the services we provide.

As you will discover in this report we are rightly proud of the achievements we have made around ensuring good nutrition to aid recovery for patients and our continued strong performance in limiting healthcare associated infections.

The introduction this year of board safety walkabouts has been another important step in our quality journey, ensuring the board hears first-hand any concerns from patients and frontline staff. Coupled with regularly hearing patients' stories at board meetings, this has helped us to promote a culture of safety right across the organisation underpinned by are our values of Everybody matters, Everything counts, Everyone’s responsible.

We know that by believing we can make a real difference to patient care, regardless of our role, we will put quality at the heart of all we do.

Our record on innovation and research is one area that reflects this drive for continuous improvement and once we have extended our portfolio and opportunities for patients here to take part in clinical trials.

We want both patients and visitors to feel confident in the quality of our services and looking ahead, under the leadership of our new medical director, our ambition is to take our clinical outcomes from good to excellent.

Our priorities this year also include two focusing specifically on care of those with dementia. This was an area that our Foundation Trust members rightly felt was important given the increasing number of patients being seen and it will give us the opportunity to further enhance our reputation for care in this area for some of the most vulnerable people in our community.

I hope that the follow pages give you a sense of our determination and commitment to the quality of care we provide, and that you read with interest our plans for the future.

I confirm that to the best of my knowledge, the information contained in this document is accurate.

Jacqueline Totterdell
Chief Executive
April 2013
## Quality Profile

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Care Quality Risk Estimates</th>
<th>October 2012</th>
<th>November 2012</th>
<th>January 2013</th>
<th>February 2013</th>
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<tbody>
<tr>
<td>Outcome 1 (R17) Respecting and involving people who use services</td>
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<tr>
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<tr>
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<tr>
<td>Outcome 6 (R24) Cooperating with other providers</td>
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<tr>
<td>Outcome 7 (R11) Safeguarding people who use services from abuse</td>
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<td>Outcome 9 (R13) Management of medicines</td>
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<td>Outcome 10 (R15) Safety and suitability of premises</td>
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<td>Outcome 11 (R16) Safety, availability and suitability of equipment</td>
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<td>Outcome 13 (R22) Staffing</td>
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<td>Outcome 21 (R20) Records</td>
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<td>Low Green</td>
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The CQC publishes its quality risk profiles a month behind the collation of data, which is itself largely historic and may be several months out of date.

As will be noted from the table below, overall the CQC has not collated any data indicating a red rating or non-compliance in respect of any outcome. Overall the Trust appears to be perceived as being in a relatively low-risk non-compliance position taking account of the low green to high red risk matrix used in the previous table as used by the CQC.

The Trust’s CQC compliance manager has continued to work with key staff to strengthen provider compliance assessments detailing the evidence relied upon to support our stated compliance position and the methods of assurance relied upon in respect of each evidence prompt. Updating collated compliance evidence held in a secure shared drive has continued to be overseen by the CQC compliance manager.
Part 2

Performance against 2012/13 priorities

As part of the Quality Account process, the trust is required to set priorities for improvement. These are issues which are considered important to patients, local communities and our stakeholders.

Use of an existing network of feedback opportunities including governor led bi-monthly public meetings, chief nurse facilitated sessions at council of governor meetings and our patient and carer experience groups, all helped to inform our priorities.

Different things matter more to different stakeholder groups but surprisingly the results were very similar. Staff’s main concerns were to reduce the death rate in hospital (SHMI), healthcare-acquired infections (HCAI), cancer 62-day targets, pressure ulcers and nutrition assessment. Members’ main priority was to reduce HCAI, followed by patient-reported outcome measures, cancer 62-day target, readmission rates and reducing the death rate in hospital.

Patient safety priorities

Healthcare Associated Infections

How did we perform?

Having been set a challenging target of having no more than one case of MRSA a year, the trust breached this target, recording three incidences in the year.

After undertaking a full root cause analysis of all the MRSA cases, all were deemed to be unavoidable.

Our performance regarding the ceiling of no more than 26 cases of C-Diff in the same time scale was below our threshold with 24 cases recorded. Overall the trust ranked 18 out of the 167 trusts nationwide for these thresholds.
Nutrition assessment on admission

How did we perform?
From a starting position 20 months previously of just over 50 per cent compliance with the requirement to undertake a nutritional assessment, the Trust is now regularly achieving over 90 per cent.

What happens next?
Despite the on-going excellent work in this area, the importance of good nutrition to wellbeing and recovery means that this priority will continue as one of our indicators for the coming year (2013/14).

What happens next?
Due to our previous excellent performance, this year we have been set a challenging target, which we are still in the process of negotiating. Our performance against these priorities will continue to be monitored via the monthly integrated performance report to the trust board.
Executive safety walkabout implementation and outcomes

Visibility of senior members of staff (members of the board), became a key priority after the 2011 staff survey which showed that this was something staff would like to see more of.

How did we perform?
During the year a total of 105 walkabouts took place. Five were postponed due to the Trust being under additional pressures, but all were rescheduled and subsequently undertaken at a later date.

During the year, the following areas of good practice were identified by the walkabout teams and reported back to the specific ward or department.

- Good team working evidence through seeing hourly care rounds in action
- A reduction in number of patient call bells heard
- A good understanding and adherence to same-sex accommodation compliance
- The development of clinical buddies to share good practice undertaken in their own areas
- Many positive comments from patients on the care they have received.

Themes for improvement that were identified during the year are:

- Lack of bedside televisions in all wards for patients
- Availability of doctors when a patient became unwell, although staff were aware that they were able to call the critical care outreach team for the patient to be reviewed by them
- Long waits for newly admitted patients to be seen by doctors on assessment units.
- Cleanliness in some ward areas when there was a shortage of domestic staff
- Patient concerns with the differing levels of staffing between day and night
- Patient concerns with disturbances from patients being “specialled” (one-to-one nursing care for non-medical reasons)

These themes were all identified through the reports that are undertaken at the time of the visit and reported to the ward managers and matrons for the area.

The reporting though action plans was improved during the last quarter and at the time of writing we are awaiting action plans for these issues to be completed.

Outcome measures for all visits reported are reported to our Quality Assurance Committee which receives bi-monthly updates on actions taken as a result of the walkabouts.

What happens next?
This priority will continue as a quality indicator for 2013/14 with the ambition to include our governors on the walkabout teams and include non-clinical areas on the itinerary.

Clinical effectiveness priorities 2012/13

62-day target for cancer waits

This is a NHS-wide target and measured in line with national guidelines. All urgent suspected cancer referrals made by GPs, where the patient is found to have cancer and receives treatment, are monitored. The 62-day period starts on the day a referral for suspected cancer is received from a GP (GMP or GDP) on a dedicated fax number or via specific services on Choose and Book, and ends when the first definitive cancer treatment is given, or where a cancer diagnosis is excluded. Clock pauses are allowed if a patient does not attend their first outpatient appointment, or if they decline an offered inpatient or day case treatment date.

Only patients diagnosed with cancer were included in the performance calculation, and patients on a pathway shared with a tertiary centre count as a half treatment.
How did we perform?
This remained a challenging target with the Trust achieving compliance in only one of the four quarters of the year.

Quarter one: 83.1 per cent
Quarter two: 84.9 per cent
Quarter three: 88.6 per cent (target achieved)
Quarter four: 83.8 per cent

Overall the target was met at 85.1 per cent for all pathways, and 90.3 per cent for those pathways originating in Southend only.

What happens next?
This priority will continue as an indicator for 2013/14 to ensure sustained compliance.

Readmission rates

A readmissions audit was completed in 2012/13 jointly by clinicians from both the primary care setting, and the Trust.

This identified that of all of readmissions, 12 per cent were the fault of the Trust and could have potentially been avoided.

How did we perform?
Although we failed to achieve the levels needed to be in the top 25th percentile, (3.97 per cent and 10.49 per cent, respectively), our readmission rates are below the national score of 100:
Elective : 96.60
Non Elective: 94.19
This means we have fewer readmissions than expected.

What happens next?
This priority will continue as an indicator for 2013/14 to ensure sustained compliance. Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Summary hospital-level mortality indicator (SHMI)

How did we perform?
Our SHMI is recorded at 1.034, above national average of 1.000, however this is within the expected range for a trust of our size, with our demographic profile.

What happens next?
This priority will continue as an indicator for 2013/14 to ensure sustained compliance. Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Patient experience priorities 2012/13
1. Cancelled operations
2. Cleanliness of bathrooms and toilets
3. Explanation of risks and benefits of operation

How did we perform?
PROMS are collated quarterly. However, because of the information captured, the surveys runs two quarters behind as it is sent to patients three months after discharge to ascertain if the intervention was successful.

Therefore the data shown overleaf is for quarter one of 2012/13.
What happens next?
A full review of the questionnaires we currently ask our patients is to be undertaken during the first six months of 2013/14 to ensure the quality of the feedback we receive.

We currently survey our patients in a variety of different ways which include:
• Patient Reported Outcome Measures
• Patient Reported Experience Measures
• Friends and Family Test
• In-patient survey in-house tracker (questions based on the national in-patient surveys sent to the wards monthly)
• National patient surveys

The action plan developed following this review will take into account where the information is reported to, what the purpose is of receiving this information is and who monitors any actions arising.
**Our chosen priorities for the year ahead (2013/14)**

Whilst the Trust may not report in its Quality Account against some previous years’ priorities, we do, nonetheless, continue to monitor against those indicators. An example of this is in the area of falls which was an indicator for the previous year (2011/12).

Data regarding this, and other quality indicators, are presented to the board of directors on a regular basis, and are monitored by senior managers and matrons to ensure that sight is not lost of these important areas.

**Patient Safety Priorities 2013/14**

**Nutrition assessment on admission**

*Why we have chosen this priority?*
Feeding our patients appropriately and making sure they have enough to drink is an essential component of good, quality care and is vital for a speedy recovery.

We have therefore chosen to continue to focus on this in recognition of the impact nutrition has on how patients feel and respond to treatment.

*How will we improve?*
We have reviewed our catering service and awarded a new catering contract to the incumbent supplier to improve the quality of catering for inpatients, visitors and staff.

We will expand our snack round pilot project to more areas and continue to promote the work of our volunteer Feeding Buddies.

We will monitor the performance of individual business units taking action and sharing best practice following audits where necessary.

*How will we measure our improvement and what are our targets?*
We will monitor compliance through nursing audits which will be reported via the nursing dashboard. Our target is a minimum of 90 per cent of patients to receive an assessment on admission.

*How will we report and monitor our progress?*
Performance throughout the year will be monitored via the monthly integrated performance report to the board.

**Recognition of the deteriorating patient**

*Why we have chosen this priority?*
It is well documented that an early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest, and can reduce mortality.

*How will we improve?*
Through regular audits to ensure compliance with our target and any actions identified and monitored within individual business units.

*How will we measure our improvement and what are our targets?*
We have set a target of 85 per cent compliance against the planned frequency of vital signs, use of the early warning system and actions taken to minimise or prevent further deterioration of patients.

*How will we report and monitor our progress?*
We will carry out a bi-annual audit of observation charts and report our progress to the Clinical Assurance Committee and escalate any issues to QAC.

**Board safety walkabouts**

*Why we have chosen this priority?*
We have chosen to continue the work introduced on this measure from last year. Patient safety walkabouts allow the Trust board to be informed first-hand regarding the safety concerns of front-line staff and patients.

They demonstrate visible commitment by listening to and supporting staff and patients when issues of safety are raised.
How will we improve?
We will see an increased compliance with our key targets outlined earlier, in particular identified actions by the walkabout team completed and implemented within six weeks of the ward visit, recorded and fed back to the ward or department and no cancelled walkabouts.

We will also extend the walkabout team to include members of our Council of Governors, further promoting a culture of openness and transparency.

How will we measure our improvement and what are our targets?
This will be measured through action plans submitted and number of walk rounds completed.

How will we report and monitor our progress?
A report will be submitted to our Quality Assurance Committee three times within the year on our progress.

Clinical effectiveness priorities 2013/14

Identification of patients with dementia

Why we have chosen this priority?
This priority has been chosen in recognition that early identification of people with dementia will lead to better outcomes for their treatment.

This was also recognised as a growing priority among our foundation trust membership, in particular during a feedback session at one of our bi-monthly member meetings.

How will we improve?
We plan to undertake baseline assessment of how many patients over the age of 75 are assessed for signs of dementia on admission.

This will then enable us to agree where improvements need to be made and the target for achieving that improvement.

How will we measure our improvement and what are our targets?
Through regular audits to ensure compliance with our target and any actions identified and monitored within individual business units.

How will we report and monitor our progress?
Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Appropriate training for staff in the care of patients with dementia

Why we have chosen this priority?
This priority has been chosen in recognition that, if staff treating those with dementia are appropriately trained, the patient has a better experience and better outcomes.

This was also recognised as a growing priority among our foundation trust membership, in particular during a feedback session at one of our bi-monthly member meetings.

How will we improve?
We will seek to increase the uptake of dementia training in identified ward areas.

How will we measure our improvement and what are our targets?
We plan to undertake baseline assessment of which wards or departments require staff to be appropriately trained.

This will then enable us to agree where improvements need to be made and the target of achieving that improvement.

How will we report and monitor our progress?
A report will be submitted to our Quality Assurance Committee, three times within the year on our progress.
Acute pain

Why we have chosen this priority?
If patients have their pain appropriately assessed and treated they will have a better outcome and experience.

How will we improve?
Through regular audits to ensure compliance with our target and any actions identified and monitored within individual business units.

How will we measure our improvement and what are our targets?
We are in the process of undertaking a Trust-wide audit of patients' satisfaction with their level of pain management.

This will enable us to baseline key areas for improvement and set a target of what we need to achieve.

The audit encompasses the following:
• Has the patient been asked how much pain they are in using the correct pain assessment tool?
• Has the patient received enough pain relief?
• How long did the patient wait for pain relief?
• Overall was the patient satisfied with the amount of pain relief that they received whilst in hospital?

How will we report and monitor our progress?
We will carry out a bi-annual audit of observation charts and report our progress to the Clinical Assurance Committee.

62-day target for cancer waits

Why we have chosen this priority?
This priority relates to a NHS-wide target and measured in line with national guidelines. All urgent suspected cancer referrals made by GPs, where the patient is found to have cancer and receives treatment, are monitored.

This remains an issue for us following last year's quality priorities and we recognise how important it is to get this right for our patients so that they get their treatment at the right time.

How will we improve?
As a designated cancer centre, we receive not only direct GP referrals but also onward referrals from neighbouring Trusts, which we have little control over in terms of lateness of referral.

We continued to work closely with our colleagues to ensure these referrals were made in a timely way to minimise the delay to patients.

The Trust also set its own internal target of seeing 90 per cent of patients, who are directly referred to us rather than via a neighbouring trust, within 62 days to ensure compliance with the overall target.

How will we measure our improvement and what are our targets?
The Trust has a target of 85 per cent of patients to begin treatment within 62 days of referral.

How will we report and monitor our progress?
Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Four-hour accident and emergency target

Why we have chosen this priority?
The number of patients using our emergency services is increasing year on year and in recent months we have struggled to meet the required target of a maximum four-hour wait.

We also recognise the importance for our patients of being treated in a timely manner and therefore chose to incorporate this into our quality indicators for the coming year.
How will we improve?
We have begun by conducting a thorough review of our admissions procedures to see where we can further improve the flow of patients so they are either admitted or treated and discharged within the required four hours.

To help us in this, we have enlisted the expertise of the NHS National Intensive Support team to help us identify areas where there is scope to make our procedures more efficient yet still clinically appropriate for our patients throughout the emergency care department, based on best practice from other acute trusts nationally.

Other work taking place includes:
• Review our staffing rotas to bring in line with our levels of activity
• Development of the emergency nurse practitioner (ENP) service with the aim of introducing an ENP led minor’s service
• Setting up an emergency pathway group to look at all patient pathways through the Trust
• Successfully implementing a new patient administration system (PAS) which will enable our clinicians to utilise real-time tracking of patients.

How will we measure our improvement and what are our targets?
The national target for compliance is 95 per cent of A&E attendances to be either admitted or treated and discharged within four hours.

This is measured and reported weekly by the A&E department.

How will we report and monitor our progress?
Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Patient experience priorities 2013/14

Supporting carers of people with dementia

Why have we chosen this priority?
This measure has recently become a national CQUIN, hence the Trust will monitor this indicator so that further engagement with carers can take place – the Trust is seeking to discover whether carers feel supported in their role.

How will we improve?
This is an area that the Trust has not measured previously, and with the increase in media coverage regarding dementia patients and their carers, we feel that the time is right to use resources to undertake studies in this area so that we can make improvements for our patients, their families and carers. We hope that the attention given to this area will also raise awareness so that additional support can be provided for those who need it.

How will we measure our improvement and what are our targets?
Bi-monthly audits comprising questions asked of carers will be carried out by the Trust’s dementia team. Targets for improvement are still being set.

How will we report and monitor our progress?
Results from the bi-monthly audits will be reported through the board’s Quality Assurance Committee.

Development of patient focus groups

Why have we chosen this priority?
Each of the Trust’s seven business units will develop patient focus groups to deal specifically with the issues that patients of that business until might face. The groups’ members will be made up of Trust members, governors and patients – clinical staff will provide input – but these groups are specifically for the benefit of service users.
How will we improve?
Each of the business units will need to assess whether a brand new group needs to be established, or whether a group could be merged with a lesser-used existing group. The groups will provide the forum for members to discuss issues that affect them directly and, through appreciating such issues, it is hoped that an in-depth understanding of patient issues will be developed and appreciated.

How will we measure our improvement and what are our targets?
Any actions that arise from the meetings will be monitored through local action trackers and fed back. Local surveys that business units identify on the feedback will be given.

How will we report and monitor our progress?
Local surveys will identity feedback provided and a summary of this will be provided tri-annually through QAC.

Pain relief

Why we have chosen this priority?
The delivery of adequate and timely pain relief (analgesia) to patients is an essential component of good-quality care. Poor pain control can lead to delayed mobilisation and recovery, an increase in complications and poor sleep. All of these can contribute to worse outcomes.

The issue has been picked up in compliant responses and also patient surveys where the Trust has consistently scored circa mid-range.

How will we improve?
By listening to our patients, understanding their needs and learning from their experiences. Provision of appropriate pain relief in a timely and professional manner to reduce suffering will be our main aim.

How will we measure our improvement and what are our targets?
Targets have not yet been set and are dependent upon the results received at the end of Q1.
How will we report and monitor our progress?
Acute and chronic pain teams will be supporting collation of the data.

The results will be monitored through QAC.
Statements of assurance from the board of directors

These statements of assurance follow the statutory requirements for the presentation of quality accounts, as set out in the Department of Health’s quality accounts regulations.

Information on the review of services:

During 2012/13 Southend University Hospital NHS Foundation Trust provided and/or sub-contracted 41 relevant health services.

Southend University Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 41 of these relevant health services.

The income generated by the relevant health services reviewed in 2012/13 represents 99.1 per cent of the total income generated from the provision of relevant health services by the Southend University Hospital NHS Foundation Trust for 2012/13.

Information on participation in clinical audits and national confidential enquiries:

During 2012/13 42 national clinical audits and three national confidential enquiries covered relevant health services provided by Southend University Hospital NHS Foundation Trust.

During 2012/13 Southend University Hospital NHS Foundation Trust participated in 84 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Southend University Hospital NHS Foundation Trust was eligible to participate in during 2012/13, and for which data collection was completed during 2012/13 are as follows:

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Category</th>
<th>Applicable to SUHFT</th>
<th>SUHFT participation</th>
<th>Participation in terms of % required</th>
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<tbody>
<tr>
<td>Adult critical care (Case Mix Programme – ICNARC CMP)</td>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>100% all critical care admissions</td>
</tr>
<tr>
<td>Renal colic (College of Emergency Medicine)</td>
<td>Acute</td>
<td>✓</td>
<td>n</td>
<td>Non participation</td>
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<tr>
<td>Severe trauma (Trauma Audit &amp; Research Network)</td>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>95%</td>
</tr>
<tr>
<td>Adult community acquired pneumonia (British Thoracic Society)</td>
<td>Acute</td>
<td>✓</td>
<td>n</td>
<td>Non participation resource issues</td>
</tr>
<tr>
<td>Emergency use of oxygen (British Thoracic Society)</td>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>100% of all patients on oxygen on day of audit</td>
</tr>
<tr>
<td>Non-invasive ventilation - adults (British Thoracic Society)</td>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>Data submission does not finish until 31st May 2013</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Laparotomy</td>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>Data collection not yet required</td>
</tr>
<tr>
<td>National Clinical Audit</td>
<td>Category</td>
<td>Applicable to SUHFT</td>
<td>SUHFT participation</td>
<td>Participation in terms of % required</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Potential donor audit (NHS Blood &amp; Transplant)</td>
<td>Blood and Transplant</td>
<td>✓</td>
<td>✓</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion (Table 3)</td>
<td>Blood and Transplant</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Lung cancer (NLCA) (Table1)</td>
<td>Cancer</td>
<td>✓</td>
<td>✓</td>
<td>115% of out expected number</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Cancer</td>
<td>✓</td>
<td>✓</td>
<td>100% of all eligible patients on-going data submission</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Cancer</td>
<td>✓</td>
<td>✓</td>
<td>100% of all eligible patients</td>
</tr>
<tr>
<td>Head and neck oncology (DAHNO)</td>
<td>Heart</td>
<td>✓</td>
<td>✓</td>
<td>100% of all eligible patients</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Heart</td>
<td>✓</td>
<td>✓</td>
<td>100% of all patients submitted</td>
</tr>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction (MINAP)</td>
<td>Heart</td>
<td>✓</td>
<td>✓</td>
<td>99.8%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Heart</td>
<td>✓</td>
<td>✓</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Cardiac arrhythmia (HRM)</td>
<td>Heart</td>
<td>✓</td>
<td>✓</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Peripheral vascular surgery (VSGBI Vascular Surgery Database, NVD)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>✓</td>
<td>96 patients submitted</td>
</tr>
<tr>
<td>Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>n</td>
<td>100% of all patients on day of audit</td>
</tr>
<tr>
<td>Inflammatory bowel disease (IBD)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>n</td>
<td>Did not participate (Resource issues)</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>✓</td>
<td>100% of eligible patients</td>
</tr>
<tr>
<td>Renal transplantation (NHSBT UK Transplant Registry)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>n</td>
<td>100% of eligible patients</td>
</tr>
<tr>
<td>Adult asthma (British Thoracic Society)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>n</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Bronchiectasis (British Thoracic Society)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>✓</td>
<td>Non participation (Resource issues)</td>
</tr>
<tr>
<td>Asthma Deaths (NRAD)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>✓</td>
<td>Only 2 cases identified both were excluded as Asthma was not primary cause of death</td>
</tr>
<tr>
<td>COPD (RCP)</td>
<td>Long term conditions</td>
<td>✓</td>
<td>✓</td>
<td>Data collection 2013/14</td>
</tr>
<tr>
<td>Fractured neck of femur</td>
<td>Older People</td>
<td>✓</td>
<td>✓</td>
<td>100% (50 patients)</td>
</tr>
<tr>
<td>National dementia audit (NAD)</td>
<td>Older People</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson’s disease (National Parkinson’s audit)</td>
<td>Older People</td>
<td>✓</td>
<td>n</td>
<td>Non participation (Resource issues)</td>
</tr>
<tr>
<td>National Clinical Audit</td>
<td>Category</td>
<td>Applicable to SUHT</td>
<td>SUHT participation</td>
<td>Participation in terms of % required</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Sentinel Stroke/National Audit Programme (SINAP)</td>
<td>Older People</td>
<td>✓</td>
<td>✓</td>
<td>An organisational audit no patient data submitted 100% (up until the end of Dec 12) now rebranded as from the 1st April 2013 as SNNAP</td>
</tr>
<tr>
<td>Hip fracture database (NHFD) (Table 4)</td>
<td>Older People</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Carotid interventions audit (CIA) (Table 2)</td>
<td>Older People</td>
<td>✓</td>
<td>✓</td>
<td>100% 52/52</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
<td>Other</td>
<td>✓</td>
<td>✓</td>
<td>53-60% of eligible patients per quarter.</td>
</tr>
<tr>
<td>Paediatric fever (College of Emergency Medicine)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>n</td>
<td>Non participation (Data not submitted)</td>
</tr>
<tr>
<td>Maternal infant and perinatal (MBRRACE-UK)*</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric asthma (British Thoracic Society)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>n</td>
<td>Non participation (Not every Trust participates)</td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>n</td>
<td>Non participation (Not every Trust participates)</td>
</tr>
<tr>
<td>Child Health (CHR-UK)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>✓</td>
<td>100% (only one patient submitted)</td>
</tr>
<tr>
<td>Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>✓</td>
<td>497 total submissions</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Women's &amp; Children's Health</td>
<td>✓</td>
<td>✓</td>
<td>100% of eligible patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCEPOD</th>
<th>Category</th>
<th>Applicable to SUHT</th>
<th>SUHT participation</th>
<th>Participation in terms of % required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Outcome and Death (NCEPOD) Cardiac Arrest Procedures</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Subarachnoid Haemorrhage</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>5 cases identified NCEPOD excluded 3, so only 2 cases submitted</td>
</tr>
<tr>
<td>Alcohol related liver</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>3 cases included 100%</td>
</tr>
</tbody>
</table>

The reports of 16 published national clinical audits were reviewed by the provider in 2012/13 and Southend University Hospital NHS Foundation Trust intends to take the listed actions to improve the quality of healthcare.

It should be noted that reports from some of these national studies have not yet been published, and data collection is still on-going.
National lung cancer audit | Our surgical resection rate is a yearly focus of review at our network audit
---|---
National lung cancer audit | All patients with borderline fitness are offered a surgical opinion
National lung cancer audit | All patients with small cell lung cancer are reviewed by an oncologist within a week of diagnosis and chemotherapy is offered within 3 weeks
National lung cancer audit | Our chemo rates for small cell lung cancer are again a focus of annual audit across the network
National lung cancer audit | We have changed our pathway so that all patients have a CT scan prior to being first seen in clinic and therefore 100% will have a CT scan prior to bronchoscopy
National lung cancer audit | The major drive is to increase surgical resection rate, to that end we have instigated a pre-diagnosis MDT to review radiology ensuring that patients who are potentially suitable for radical treatment are identified early and appropriate diagnostic staging and assessment of fitness is carried out.

Table 1

NB= It should be noted that these actions have already resulted in an increase in our surgical resection rate and this has been included as a case study within the national lung cancer audit report.

Table 2

| National carotid interventions audit (CIA) | The report showed once again that we were performing very well. We have a low complication rate and are able to offer 88% of patients’ surgery within two weeks of symptoms. This places us third nationally |

Table 3

| National comparative audit - Blood sampling/ labelling for transfusion | The report showed once again that we were performing very well. We have a low complication rate and are able to offer 88% of patients’ surgery within two weeks of symptoms. This places us third nationally |
| National comparative audit - Blood sampling/ labelling for transfusion | Competency assessments need repeating every two years |
| National comparative audit - Blood sampling/ labelling for transfusion | Sample collection for transfusion is part of the junior doctor induction and all nurses and other clinical staff have to be trained and competency assessed prior to procedure being carried out |

Table 4

Audit of information submitted to the National Hip Fracture Database (NHFD) – 2012:

| National hip fracture database(NHFD) | New ‘fracture NOF’ proforma was introduced and patients are being fast tracked to Southbourne ward under the joint care of the geriatricians and orthopaedic surgeons. This should improve our performance further |
| National hip fracture database(NHFD) | It was recommended that we review and discuss the NHFD annual report and check annually the accuracy of our coding |
| National hip fracture database(NHFD) | There is a strong emphasis in the departments on good documentation |
| National hip fracture database(NHFD) | Inaccuracies in coding of fracture classification and operations were identified. These have been discussed in the department and dealt with |
The reports of five local clinical audits were reviewed by the provider in 2012/13 and Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Department</th>
<th>Speciality</th>
<th>Audit</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Audiology</td>
<td>Audit of ABR waveforms</td>
<td>Review the process for rejecting a waveform</td>
</tr>
<tr>
<td>Surgery</td>
<td>Audiology</td>
<td>Audit of ABR waveforms</td>
<td>Review the capabilities of AEP in recording comments</td>
</tr>
<tr>
<td>Surgery</td>
<td>Audiology</td>
<td>Audit of ABR waveforms</td>
<td>Amend ABR protocol to include how we record rejected waveforms</td>
</tr>
<tr>
<td>Surgery</td>
<td>ENT</td>
<td>Role of routine nasopharyngeal biopsy in adult secretory otitis media</td>
<td>Adoption of new departmental protocol for the management of adult patients with new onset secretory otitis media (glue ear)</td>
</tr>
<tr>
<td>Corporate</td>
<td>Pharmacy</td>
<td>Drug prescription chart audit</td>
<td>Change the allergy status to guide prescriber into completing all components</td>
</tr>
<tr>
<td>Corporate</td>
<td>Pharmacy</td>
<td>Drug prescription chart audit</td>
<td>Design a “how to use the drug chart” guide for doctors including how to cancel prescription record devices for insulin patients and recording their contact details</td>
</tr>
<tr>
<td>Surgery</td>
<td>Audiology</td>
<td>Audit of ABR waveforms</td>
<td>Amend ABR protocol to include how we record rejected waveforms</td>
</tr>
<tr>
<td>D&amp;T</td>
<td>Oncology</td>
<td>Pragmatic approach to EGFR mutation testing in advanced lung cancer</td>
<td>Improvement of successful tissue testing by increasing quantity and quality of biopsy</td>
</tr>
<tr>
<td>D&amp;T</td>
<td>Oncology</td>
<td>Pragmatic approach to EGFR mutation testing in advanced lung cancer</td>
<td>Early engagement and discussion with intervention radiologists and respiratory physicians need to take place</td>
</tr>
<tr>
<td>D&amp;T</td>
<td>Oncology</td>
<td>Pragmatic approach to EGFR mutation testing in advanced lung cancer</td>
<td>To reduce time delay of EGFR analysis early MDT discussion to identify patients who would benefit from testing and prompting early initiation of testing</td>
</tr>
<tr>
<td>Medicine</td>
<td>Acute medicine</td>
<td>AMU discharge summary audit</td>
<td>Discharge summaries to form part of work-place assessments for all trainees</td>
</tr>
<tr>
<td>Medicine</td>
<td>Acute medicine</td>
<td>AMU discharge summary audit</td>
<td>AMU discharge summary guidance to be written and distributed</td>
</tr>
</tbody>
</table>
Information on participation in clinical research:
The number of patients receiving relevant health services provided or sub-contracted by Southend University Hospital NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 967.

Information on the use of the CQUIN framework:
A proportion of Southend University Hospital NHS Foundation Trust’s income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between Southend University Hospital NHS Foundation Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2012/13 and for the following 12-month period are available online at the Monitor website

The amount of income received by Southend University Hospital NHS Foundation Trust in 2012/13 that was conditional upon achieving quality improvement and innovation goals was £1,902,861, (£219,084 in 2011/12).

Information relating to registration with the Care Quality Commission and periodic / special reviews:
Southend University Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional registration.

The Care Quality Commission has not taken enforcement action against Southend University Hospital NHS Foundation Trust during 2012/13.

Southend University Hospital NHS Foundation Trust has not been subject to any special reviews or investigations by the CQC during the reporting period.

Information on the quality of data:
Southend University Hospital NHS Foundation Trust submitted records during 2012/13 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:
  99.8% for admitted patient care (national average = 99.1%);
  99.9% for outpatient care (national average = 99.3%)
  99.2% for accident and emergency care (national average = 94.9%)

- which included the patient’s valid General Practitioner Registration Code was:
  100% for admitted patient care (national average = 99.9%)
  100% for outpatient care (national average = 99.9%)
  100% for accident and emergency care (national average = 99.7%)

Southend University Hospital NHS Foundation Trust’s information governance assessment report overall score for 2012/13 was 81 per cent and was graded green.

Southend University Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was four per cent.

- The audit sample was based on 10 HRGs (healthcare resource groups) selected by the cluster covering pneumonia, respiratory failure, heart failure and kidney or urinary tract infections, 128 spells were tested. The results should not be extrapolated further than the actual sample audited.

Southend University Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

a) improve the quality and filing of case notes
b) provide training to staff on the issues noted in the errors agreed by the Trust
Information made available by the Health and Social Care Information Centre:

All trusts are now required to report against a core set of indicators using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. Some of the indicators are not relevant to this Trust – for instance, ambulance response times which are relevant to ambulance trusts only.

Those that are applicable to Southend University Hospital NHS Foundation Trust are shown in the table below.

<table>
<thead>
<tr>
<th>Prescribed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measurement of SHMI</strong> - (a) the value and banding of the summary hospital-level mortality indicator (&quot;SHMI&quot;) for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. <em>The palliative care indicator is a contextual indicator.</em></td>
</tr>
<tr>
<td><strong>Reporting of National PROMS</strong> - (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.</td>
</tr>
<tr>
<td><strong>Readmission rates</strong> - Percentage of patients aged— (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.</td>
</tr>
<tr>
<td><strong>The trust’s responsiveness to the personal needs of its patients during the reporting period.</strong></td>
</tr>
<tr>
<td><strong>Staff Friends and Family test</strong> - The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</td>
</tr>
<tr>
<td><strong>VTE</strong> - The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.</td>
</tr>
<tr>
<td><strong>C Difficile cases</strong> The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period.</td>
</tr>
<tr>
<td><strong>Patient safety incidents</strong> - The number of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</td>
</tr>
</tbody>
</table>

Where the necessary data is made available by the Health and Social Care Information Centre (HSCIC), we have shown a comparison of numbers, percentages, values, scores or rates (as appropriate) for each of the indicators that are applicable to this Trust, with regard to:

- the national average for the same; and
- those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same.
Measurement of SHMI:
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Regular quarterly reports are produced by the information team and monitored by the clinical assurance committee and the clinical quality review group.
- A more detailed analysis of each quarterly SHMI result is undertaken to identify any outliers in terms of performance at specialty, consultant or procedure level.
- Patient-level clinically based audits are undertaken where necessary to identify any procedural, systemic, or clinical care anomaly which needs to be addressed.
- The SHMI is also reported to the Trust board on a monthly basis as part of our integrated performance report.

Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services:

Our SHMI is recorded at 1.034, above the national average of 1.000, however this is within the expected range for a trust of our size, with our demographic profile.

SHMI will continue as a quality indicator for 2013/14 to ensure sustained compliance. Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Reporting of PROMS:
Southend University Hospital NHS Foundation Trust considers the scores are as described for the following reasons:

- Uptake of the PROMS survey to date has been low.
- Due to this we have changed the process for the pre-op assessment of our patients and have started to run a seminar class during which patients have the opportunity to participate in the PROMS data collection.

This has encouraged greater participation and in turn will, we believe, improve our overall scores in the future.

Southend University Hospital NHS Foundation Trust intends to take the following actions to improve these outcome scores, and so the quality of its services:

- Trauma nurses are the point of contact for patients throughout their operation and on discharge so that patients can address any queries regarding their operation or follow up care.

We also intend to commence an enhanced recovery programme during the next year.
### Groin Hernia

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2010</td>
<td>31/03/2011</td>
<td>0.082</td>
<td>0.082</td>
<td>67/130</td>
</tr>
</tbody>
</table>

### Varicose Vein

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2010</td>
<td>31/03/2011</td>
<td>0.024</td>
<td>0.088</td>
<td>66/69</td>
</tr>
</tbody>
</table>

### Hip Replacement

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2010</td>
<td>31/03/2011</td>
<td>0.352</td>
<td>0.394</td>
<td>127/138</td>
</tr>
</tbody>
</table>

### Knee Replacement

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2010</td>
<td>31/03/2011</td>
<td>0.282</td>
<td>0.291</td>
<td>93/141</td>
</tr>
</tbody>
</table>

(Where the value is the “Adjusted average health gain” as detailed in the HSCIC)
Reporting of re-admissions:
Southend University Hospital NHS Foundation Trust considers that these percentages are as described for the following reasons:

A readmissions audit was completed in 2012/13 jointly by clinicians from both the primary care setting and the Trust.

This identified that of all readmissions, 12 per cent were the fault of the Trust and could have potentially been avoided.

Southend University Hospital NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Readmissions within 30 days are monitored monthly and reported via the monthly integrated performance report to the board.
- Patient lists have been made available in order for areas to be able to look at their avoidable readmissions.
- Local audits have been done to look at the reasons for readmissions and, where appropriate, changes have been made to processes in order to improve accuracy of reporting.
- A weekly report which looks at patients who have been readmitted and are currently in the hospital goes to the discharge team to see if they could have been avoided and investigates the reasons why they have been readmitted.
- During quarter two, two targets (elective / non elective) were added to the integrated performance report which, if attained, would put the Trust in the top 25th percentile of our peers (other university hospitals).
- We set these at 3.25 per cent of all discharges for re-admissions following an elective admission and 9.5 per cent of all discharges following a non-elective admission.
- This priority will continue as an indicator for 2013/14 to ensure sustained compliance.
- Performance throughout the year will be monitored via the monthly integrated performance report to the board.

Reporting from the last two complete quarters:

<table>
<thead>
<tr>
<th>Category</th>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients under 14</td>
<td>01/10/2012 - 31/12/2012</td>
<td>3.02%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>01/07/2012 - 30/09/2012</td>
<td>2.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients aged 15+</td>
<td>01/10/2012 - 31/12/2012</td>
<td>7.33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>01/07/2012 - 30/09/2012</td>
<td>7.12%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reporting of the Trust’s responsiveness to the personal needs of its patients:
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

We have been undertaking internal patient surveys that reflect the questions in the national surveys so that wards are able to have a real time view of how they are performing with regards to the personal needs of patients.

Southend University Hospital NHS Foundation Trust intends to take action to improve this percentage, and so the quality of services.

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>66.0</td>
<td>67.4</td>
<td>94/161</td>
<td>(56.5) NORTH WEST LONDON HOSPITALS NHS TRUST</td>
<td>(85) QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>01/04/2010</td>
<td>31/03/2011</td>
<td>64.0</td>
<td>67.3</td>
<td>129/161</td>
<td>(56.7) MAYDAY HEALTHCARE NHS TRUST</td>
<td>(82.6) QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST</td>
<td></td>
</tr>
</tbody>
</table>

Measurement of staff who would recommend the trust as a provider of care to their family or friends

<table>
<thead>
<tr>
<th>Period</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 survey</td>
<td>68.0</td>
<td>65.0</td>
<td>56/161</td>
<td>(35) North Cumbria University Hospitals NHS Trust</td>
<td>(94) Queen Victoria Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>2011 survey</td>
<td>67.0</td>
<td>65.0</td>
<td>64/166</td>
<td>(33) Croydon Health Services NHS Trust</td>
<td>(96) Clatterbridge Centre For Oncology NHS Foundation Trust</td>
</tr>
</tbody>
</table>

Present data relating to the percentage of staff employed by, or under contract to the Trust, who would recommend the trust as a provider of care to their family or friends.

2012 staff survey data:

Key Finding 24 – Staff recommendation of the Trust as a place to work or receive treatment (scale of 1 -5 the higher score the better) =

Southend University Hospital: 3.67 (2011 – 3.57)
Acute trusts in England Average = 3.57
Best score for acute trusts in England = 4.08

Southend University Hospital is ranked above (better than) average compared with all acute Trusts in England.
The 2012 NHS staff survey did not have a question specifically asking whether staff would recommend the Trust as a provider of care to their family and friends. The nearest to this are:

(percentages quoted are those agreeing / strongly agreeing with the statement)

**Question 9a “I am satisfied with the quality of care I give to patients / services users”:**
- Southend University Hospital: 74 per cent.
- Acute trusts in England average (median): 73 per cent

**Question 9c “I am able to deliver the patient care I aspire to”:**
- Southend University Hospital: 55 per cent.
- Acute trusts in England average (median): 55 per cent

**Question 12d “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”:**
- Southend University Hospital: 68 per cent.
- Acute trusts in England average (median): 60 per cent

Southend University Hospital NHS Foundation Trust considers that this percentage is as described for the following reasons:

Although our score is above average, we are aware our staff rightly aspires to the very highest standards of care which has a bearing on their response to this question.

The Trust is actively engaging with staff to establish what would make them more satisfied with the level of service they are able to provide.

Services have been under enormous pressure due to sustained high demand through the autumn / winter of 2012-13.

Southend University Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

We have developed a calendar of engagement opportunities including our staff focus group (the Have Your Say group) and staff representatives of our Staffside to identify meaningful actions to achieve an improvement.

Business units have all received data for their areas to enable local actions to be implemented.

We are continuing to promote our ‘Have Your Say’ email facility to enable staff to give confidential feedback and ideas to the Trust to help improve the care we provide.

We are continuing to embed our core values of Everybody matters, Everything counts and Everyone’s responsible to support the achievement of our organisational aim of delivering ‘Excellent Care by Excellent People’.

We launched a new staff appraisal scheme in April 2013 to support this process and to provide an additional opportunity for staff to give feedback and make proposals for the improvement of patient care.
### Measurement of VTE

**VTE return - data submissions**

<table>
<thead>
<tr>
<th>Final submitted position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong></td>
<td><strong>Number of Risk Assessments</strong></td>
</tr>
<tr>
<td>Apr-12</td>
<td>5587</td>
</tr>
<tr>
<td>May-12</td>
<td>6379</td>
</tr>
<tr>
<td>Jun-12</td>
<td>5581</td>
</tr>
<tr>
<td>Jul-12</td>
<td>6067</td>
</tr>
<tr>
<td>Aug-12</td>
<td>6004</td>
</tr>
<tr>
<td>Sep-12</td>
<td>5716</td>
</tr>
<tr>
<td>Oct-12</td>
<td>6507</td>
</tr>
<tr>
<td>Nov-12</td>
<td>6209</td>
</tr>
<tr>
<td>Dec-12</td>
<td>5582</td>
</tr>
<tr>
<td>Jan-13</td>
<td>6420</td>
</tr>
<tr>
<td>Feb-13</td>
<td>6004</td>
</tr>
</tbody>
</table>

Southend University Hospital NHS Foundation Trust considers that this percentage is as described for the following reasons:

- The data relates to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2012</td>
<td>31/12/2012</td>
<td>97.3%</td>
<td>94.1%</td>
<td>24/162</td>
<td>(84.6%) CROYDON HEALTH SERVICES NHS TRUST</td>
<td>(100%) SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>01/07/2012</td>
<td>30/09/2012</td>
<td>97.0%</td>
<td>93.8%</td>
<td>20/162</td>
<td>(80.9%) PLYMOUTH HOSPITALS NHS TRUST</td>
<td>(100%) Various trusts</td>
<td></td>
</tr>
</tbody>
</table>

Southend University Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Putting in place a dedicated VTE lead nurse
- Providing regular education at induction for newly recruited doctors and nurses.
- Link nurses in each ward and business units to work on behalf of VTE working group.

- Close monitoring on the compliance and performance by regular audits, analysis of results and actions based on them.
- Motivation and rewards for the best performance.
- Reminders and more education for the underperforming areas (wards and personnel).
Measurement of C Difficile cases:
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the last two reporting periods.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Q3</th>
<th>Q4</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>1,039</td>
<td>1,184</td>
<td>2,223</td>
</tr>
<tr>
<td>20-49</td>
<td>7,363</td>
<td>6,789</td>
<td>14,152</td>
</tr>
<tr>
<td>50-64</td>
<td>6,305</td>
<td>6,269</td>
<td>12,574</td>
</tr>
<tr>
<td>65-74</td>
<td>8,475</td>
<td>8,986</td>
<td>17,461</td>
</tr>
<tr>
<td>75-84</td>
<td>12,416</td>
<td>13,777</td>
<td>26,193</td>
</tr>
<tr>
<td>85+</td>
<td>11,816</td>
<td>14,182</td>
<td>25,998</td>
</tr>
<tr>
<td>Grand Total</td>
<td>47,414</td>
<td>51,187</td>
<td>98,601</td>
</tr>
</tbody>
</table>

Age Group | Q3 | Q4 | Grand Total |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;72 Hours</td>
<td>8</td>
<td>9</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3</th>
<th>Q4</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.87</td>
<td>17.58</td>
<td>17.24</td>
</tr>
</tbody>
</table>

Default age group bandings. 
Excluding patients two years and under. And also excluded Orsett activity. Quarters are based on discharge date. On top of these bed days, there were also 25,408 discharges which occurred on the same day as admission i.e. zero bed days, of which 20,671 were day cases.

Southend University Hospital NHS Foundation Trust considers that this rate is as described for the following reasons:

The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the last two reporting periods.

Southend University Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by:

- Adhering to strict antibiotic stewardship
- Double testing for suspected C.diff infections. GDH (Glutamate Dehydrogenase) This identifies C.diff carriers. These patients are isolated if having loose stools
- Regular infection prevention and control training in relation to C.diff for appropriate staff
- A robust root cause analysis process following a case. All lessons learned are shared and acted on
- The use of Tristel trigger spray (Chlorine based product) for the cleaning of all commodes and toilet areas
Measurement of patient safety incidents:

Southend University Hospital NHS Foundation Trust considers that this number / rate is as described for the following reasons.

The number of patient safety incidents reported within the Trust during the reporting periods and the number and percentage of such patient safety incidents that resulted in severe harm or death.

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of Patient H&amp;S incidents/near misses</th>
<th>Number of incidents severity rating high or extreme</th>
<th>Percentage of severe harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-13</td>
<td>5968 (31.02 by 1000 bed days)</td>
<td>36</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2011</td>
<td>30/09/2011</td>
<td>5.8 (severe harm/death=8, 0.3%)</td>
<td>6.39 (severe harm/death=16, 0.7%)</td>
<td>17/49</td>
<td>13.01) BASINGSTOKE AND NORTH HAMPSHIRE NHS FOUNDATION TRUST</td>
<td>(2.91) WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST</td>
<td></td>
</tr>
</tbody>
</table>

Southend University Hospital NHS Foundation Trust has taken the following actions to improve this number and /or rate, and so the quality of its services, by:

- Further education and training for staff on incident reporting and near-miss reporting
- Auditing the length of time from reporting to management sign off
- Will continue to work closely with our clinical commissioning groups on reporting serious incidents and never events, along with sharing action plans.
- All actions plans are monitored through the clinical assurance committee, with escalation to the quality assurance committee for high level and incomplete action plans.
Part 3

Other information

What is quality, and why is it important?

What does ‘quality’ mean? Getting the right service, free from mistakes, when you need it?

While quality in healthcare is the buzzword of the moment, it is not always easy to define as quality means different things to different people.

Some people think that getting quality healthcare means seeing a doctor right away, being treated courteously by hospital staff, or having the doctor spend a lot of time with the patient and their family. While those are important elements, for us, as an organisation, clinical and safe quality of care is also paramount. This can easily defined as doing the right thing (getting the healthcare services you need), at the right time (when you need it), in the right way (using the appropriate test or procedure and being treated with respect) to achieve the best possible results.

That is important because offering safe and proven high-quality care, leads to more lives saved and less time in the hospital.

An overview of the quality of care, based on performance in 2012/13

1) Domains of quality: patient safety

Healthcare Associated Infections:

Why was this priority chosen?

Southend University Hospital used this indicator as a measurement of quality in its 2011/12 Quality Account, and continued to do so for 2012/13.

Healthcare associated infections remain a key priority for the NHS as a whole, and whilst the Trust has improved its incidence if such infections over a number of year, it was considered an area where continual and sustained improvement is vital

What did we did we do to improve?

Data is now captured on a daily basis with a full root-cause analysis undertaken for every hospital acquired and health care associated infection, to ensure any lessons that can be learned are picked up and fed back.

Instances of MRSA:

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/2011</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2011/2012</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2012/2013</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Each month the total number of cases of clostridium difficile infection (C-Diff) are reported to the Trust board via our integrated performance report.

Instances of C.Diff:

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/2011</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>2011/2012</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>2012/2013</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>24</td>
</tr>
</tbody>
</table>

All data shown in the above tables is collated in-house by our own infection control team and is governed by standard national definitions.
Nutrition assessment on admission:

Why was this priority chosen? Nutritional assessment on admission is an important factor in the health and wellbeing of our patients and can impact on areas such as recovery from illness, wound healing, vulnerability to infection, muscle strength and mental health.

We wanted to make sure that all appropriate patients received a nutrition assessment on admission to our hospital as this is extremely important in helping us to develop correct care plans for patients who are at risk of poor nutrition and hydration and allow us to provide a high standard of patient care.

What did we do to improve? Patients admitted to our hospital are now required to undergo a nutritional screening assessment on admission in order to identify potential malnutrition or risk of malnutrition. Core care plans have been developed, which enable nursing staff to identify individual plans of care in accordance with the level of nutritional support and clinical intervention required as well as monitoring of the patient’s nutritional status.

Six key criteria relating to nutritional assessment and care have been incorporated in the head nurse quality indicators, which are monitored through clinical audit by matrons and published monthly in the nursing dashboard. The criteria measured are:

- Nutritional assessment completed within 24 hours of admission to the ward / pre-assessment.
- Patient’s weight on admission is documented.
- Patients identified with moderate to high nutritional risk have a core care plan completed.
- Patients identified with high nutritional risk are referred to a dietician.
- Patients identified with high nutritional risk have been weighed in accordance with the care plan.
- Nutritional assessment re-assessed at least weekly.

This has enabled matrons and nursing teams to identify where practice improvements can be made at ward level.

The multi-professional action group for nutrition has merged with the dignity and respect action group to form the dignity and nutrition group.

This now has a broad membership, including service users and is strongly engaged in driving improvement in nutritional care within the hospital.

This group has led the introduction of snack rounds in an elderly care ward and cancer / oncology wards. These enable us to provide additional snacks between lunch and evening meal to increase a patient’s dietary intake and has been positively received by patients and carers.

The dignity and nutrition group have also been working with the catering service providers to review menus and meals offered, including the special modified texture diets.

Executive safety walkabout implementation and outcomes

Why was this priority chosen? It has long been acknowledged within the NHS that visibility of members of the Trust board engenders a culture of safety within the organisation.

Patient safety walkabouts allow the Trust board to be informed first-hand regarding the safety concerns of front-line staff and patients.

They demonstrate visible commitment by listening to and supporting staff and patients when issues of safety are raised. Executive visibility was also a key priority identified by our staff in our 2011 staff survey.
What did we do to improve?
Each walkabout it undertaken by an executive or non-executive director accompanied by a matron.

A number of outcome measures were identified as key to the success of the initiative: actions identified by the walkabout team should be completed and implemented within six weeks of ward visit record and fed back to the ward or department.

Increase in attendance at the walkabouts from ward staff following initial implementation.
Increased awareness of the patient safety agenda, monitored through the staff survey.
No cancelled walkabouts.

Increase in the perception of staff that senior management is visible.

Data was collected through the feedback from the clinical buddy reports submitted following the walkabout and then reported to the board’s quality assurance committee in a quarterly Quality Account update.

2) Domains of quality:
Clinical effectiveness

62-day target for cancer waits:

Why was this priority chosen?
The Trust has had difficulty in achieving this target, breaching in 2011/12, which resulted with our red governance rating in December 2011. It has been difficult to sustain improvements made by the end of the previous financial year, and so, it was agreed that this should remain as a 2012/13 indicator, and continues to be used as a quality indicator for 2013/14.

This priority relates to a NHS-wide target and is measured in line with national guidelines.

All urgent suspected cancer referrals made by GPs, where the patient is found to have cancer, and receives treatment, are monitored.

The Trust has an internal target of 85% of patients to begin treatment within 62 days of referral.

What did we do to improve?
The Trust invited the NHS National Intensive Support Team for cancer to come and independently review our pathways for cancer patients to ensure they were as effective, efficient and patient-centred as possible.

As a designated cancer centre we not only receive direct GP referrals but also onward referrals from neighbouring trusts, which we have little control over in terms of lateness of referral.

We continued to work closely with our colleagues to ensure these referrals were made in a timely way to minimise the delay to patients.

The Trust also set its own internal target of seeing 90 per cent of patients within 62 days, who are directly referred to us rather than via a neighbouring trust, to ensure compliance with the overall target.

Cancer target performance throughout the year was monitored via the monthly integrated performance report to the board.

The table shows the Trust’s performance against 62-day cancers over the last two financial years.
Cancer 62 day waits for first treatment comprising either:

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Period</th>
<th>2011/12 Q1</th>
<th>2011/12 Q2</th>
<th>2011/12 Q3</th>
<th>2011/12 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>From urgent GP referral</td>
<td>&gt;85%</td>
<td>80.3%</td>
<td>82.5%</td>
<td>78.8%</td>
<td>86.2%</td>
</tr>
<tr>
<td>From consultant led screening service referral</td>
<td>&gt;90%</td>
<td>89.2%</td>
<td>90.0%</td>
<td>100%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Period</td>
<td>2012/13 Q1</td>
<td>2012/13 Q2</td>
<td>2012/13 Q3</td>
<td>2011/13 Q4</td>
<td></td>
</tr>
<tr>
<td>From urgent GP referral</td>
<td>&gt;85%</td>
<td>82.7%</td>
<td>84.7%</td>
<td>88.7%</td>
<td>83.5%</td>
</tr>
<tr>
<td>From consultant led screening service referral</td>
<td>&gt;90%</td>
<td>92.6%</td>
<td>100%</td>
<td>95.2%</td>
<td>94.3%</td>
</tr>
</tbody>
</table>

The chart below specifically shows our performance throughout the 2012/13 year against our internal 90 per cent target (re urgent referral).

Readmission rates:

Why was this priority chosen?
Southend University Hospital used this indicator as a measurement of quality in its 2011/12 quality account, and continued to do so for 2012/13.

Our internal readmissions reports use admissions data input into our PAS system and mimics the Dr Foster algorithms so that we can get early indication on how we are performing.

We locally report 30-day readmissions but in order to benchmark against other Trusts we have to use 28-day readmissions from Dr Foster which uses SUS data submitted by all Trusts. Although readmissions are all non-elective, here at Southend we split them into two groupings (those following an elective admission and those following a non-elective admission). Readmissions cannot automatically be filtered by whether they were avoidable or not. Therefore, all measures of readmissions include all readmissions whether for the same diagnosis or not.
**What did we do to improve?**

Readmissions within 30 days are monitored monthly and reported via the monthly integrated performance report to the board.

Patient lists have been made available in order for areas to be able to look at their avoidable readmissions.

Local audits have been done to look at the reasons for readmissions occurring and where appropriate changes have been made to processes in order to improve accuracy of reporting.

A weekly report which looks at patients who have been readmitted and are currently in the hospital goes to the discharge team to assess if they could have been avoided and investigates the reasons they have been readmitted.

During quarter two, two targets (elective / non elective) were added to the integrated performance report which, if attained, would put the Trust in the top 25th percentile of our peers (other university hospitals).

We set these at 3.25 per cent of all discharges for re-admissions following an elective admission and 9.5 per cent of all discharges following a non-elective admission.

**a) Re-admissions after an elective admission**

Last financial year (April 2011 to March 2012) inclusive, the Trust had a readmission rate of 4.28% and was 21/27 Trusts in the SHA and 5/5 of the main Essex hospitals. Our percentage re-admissions YTD (April 12 to October 12 inclusive) were 4.34% which made us 19/26 Trusts in the SHA and 5/5 of the main Essex Hospitals. We have a relative risk YTD of 96.90 which means we are lower than national average (100).

**b) Re-admissions after a non-elective admission**

Last financial year (April 2011 to March 12) inclusive, the Trust had a readmission rate of 9.44% and was 19/27 Trusts in the SHA and 4/5 of the main Essex hospitals. Our percentage re-admissions YTD (April 12 to October 12 inclusive) were 9.46% which made us 19/27 Trusts in the SHA and 4/5 of the main Essex hospitals. We have a relative risk YTD of 94.19 which means we are lower than national average (100).

The five main Essex hospitals are as follows:

1. Colchester Hospital University NHS Foundation Trust
2. Mid Essex Hospital Services NHS Trust
3. Basildon and Thurrock University Hospitals NHS Foundation Trust
4. The Princess Alexandra Hospital NHS Trust
5. Southend University Hospital NHS Foundation Trust

**Summary hospital-level mortality indicator (SHMI)**

**Why was this priority chosen?**

The hospital standardised mortality ratio (HSMR), the measure of relative risk of death, was historically recognised as not being an accurate mortality indicator.

In an attempt to address the shortcomings of the HSMR indicator, a full consultation was undertaken by the Department of Health during 2010/11 to develop a new, more comprehensive mortality indicator.

The result of this consultation was the development of the summary hospital-level mortality indicator (SHMI), which is now recognised as the primary indicator for measuring mortality by the Department of Health.

This is a quality indicator that all trusts are required to report in their quality accounts and was recorded as at 1.032 at the end of the year.

**What did we do to improve?**

Regular quarterly reports are produced by the Trust’s information team and monitored by the clinical assurance committee and the clinical quality review group.

A more detailed analysis of each quarterly SHMI result is undertaken to identify any outliers in terms of performance at specialty, consultant or procedure level.

Patient-level clinically based audits are undertaken where necessary to identify any procedural, systemic, or clinical care anomaly which needs to be addressed.

The SHMI is also reported to the Trust board on a monthly basis as part of our integrated performance report.
3) Domains of quality: Patient experience

- Cancelled operations:
- Cleanliness of bathrooms and toilets
- Explanation of risks and benefits of operation

Why were these priorities chosen?
A good experience of our hospital does not just mean receiving good care. We want to ensure that people receiving our services feel reassured, as free from stress as possible and to be treated in a clean and safe environment.

There are 48 questions we ask our patients in our patient reported outcomes measures surveys (PROMS), which are measured quarterly.

The above three areas consistently performed poorly during 2011/12. We therefore identified these as key indicators for 2012/13 that will allow us to monitor our success in achieving an improved patient experience.

What did we do to improve?
1. The theatre schedule has been changed to tighten the monitoring and control of bookings so as to decrease the number of cancelled operations.
2. Domestic staff and matrons are completing regular audits of the standard of cleanliness, and the head of estates and facilities is reviewing daily domestic checking schedules.
3. A review is being undertaken of the written information that our patients receive on the risks and benefits of operations to complement the verbal information that is

The data below is taken from the most recent in-patient survey results and the table below shows that the Trust was in the bottom 20% of Trusts for Q7 and average for the other two.

<table>
<thead>
<tr>
<th>Question</th>
<th>Question Text</th>
<th>Own Score</th>
<th>Min</th>
<th>Max</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7</td>
<td>Was your admission date changed by hospital?</td>
<td>89</td>
<td>46</td>
<td>99</td>
<td>92</td>
</tr>
<tr>
<td>Q18</td>
<td>How clean were the toilets and bathrooms?</td>
<td>83</td>
<td>59</td>
<td>99</td>
<td>83</td>
</tr>
<tr>
<td>Q42</td>
<td>Before op., did staff explain the risks and benefits of the operation?</td>
<td>88</td>
<td>61</td>
<td>98</td>
<td>88</td>
</tr>
</tbody>
</table>

A full review of the question we currently ask our patients is to be undertaken during the first six months of 2013/14 so that we are able to determine what is best suited to our needs.

We currently survey our patients in a variety of different ways which include

- PROMS
- PREMS
- Friends and Family Test
- Inpatient survey in-house tracker (questions based on the national in patient surveys that is sent to the wards monthly)
- National Patient surveys

The action plan to be developed following this review will take into account where all of the information is circulated to and the purpose of receiving it, and will be presented to the Trust board in summer 2013.
Embedding quality at Southend University Hospital

Quality strategy
Ancient Greek philosopher Aristotle is credited with saying “quality is not an act but a habit”, a habit we aspire to develop here.

This is underpinned by our values and what they mean in regards to quality and are set out in our quality strategy 2012-2016.

Here we have linked our top three quality priorities: leadership for quality, improving the patient experience and improving clinical outcomes and avoiding harm to our values and behaviours:

**Everybody matters**
We aspire to excellence by having attention to detail and zero tolerance to anything less. Patients and staff have the right and truly deserve to both receive and give high-quality care that improves both patient and staff satisfaction in their experience in our hospital.

**Everything counts**
All patients and staff should be aware that every contact with every patient and member of staff is an opportunity to make a positive difference and that we strive to continuously improve systems and processes to promote the patient experience to be the best it can be.

**Everyone’s responsible**
By each individual acknowledging and believing that all staff are responsible and can make a real difference to patient care, regardless of their role, we will put quality at the heart of all we do.

Our four-year quality strategy was launched late in July 2012 and sets out our plans for improving quality and is about making our healthcare safer, more effective, patient-centred, timely, efficient and fair.

To ensure on-going improvement in quality, collection and monitoring of data relating to many domains of quality – not just those included in this Quality Account - are carried out on an on-going basis.

The Trust board plays an active part in reviewing the information on a monthly basis which is presented in the form of a monthly integrated performance report and includes information on:

- Complaints
- Falls
- C-diff
- MRSA
- Medication errors
- Single-sex accommodation
- Pressure ulcers
- Serious incidents

**Patient stories**
This year saw the introduction of patients’ stories, told by the person or their representative to the Trust board.

These take place quarterly and enable the board to hear first-hand from patients or their relatives about their experience in our hospital.

The stories provide details of what has gone well or not so well during their admission. It also gives staff the opportunity to tell the board what changes they have put in place to prevent similar events happening or how they are sharing good practice.

**Patient and carer involvement**
We want to continue to improve both the clinical care we provide and our patients’ overall experience at the hospital.

We aim to do this by listening to what our patients tell us and by putting their suggestions into practice.

Our hospital has a long history of involving patients, the public and its foundation trust members in ensuring we provide high-quality services which are responsive to the needs of the diverse community that we serve.
We are in the process of launching a patient and carers’ forum to help us develop services that are better targeted, more effective and more likely to meet the expectations of the people who use them.

We want forum members to be drawn from a variety of backgrounds but share a common interest in our hospital and the standard of service we provide.

In order to undertake this, a patient and carer focus group has been set up with the following aims:

• Stage 1 - Create a register of patient and carers who wish to be involved in the Trust’s service changes, maintained by the membership manager.

• Stage 2 - Establish a forum for patients and carers in which they are encouraged and enabled to influence and contribute actively to the Trust’s strategic decisions and annual planning.

These stages will strengthen the achievement of our annual plan by supporting specific programmes of work and providing the perspective of patients in their relevant area of interest and gaining their feedback and engagement to service change for improvement.

Serious incidents and never events
During the course of 2012/13 there have been four never events recorded on our serious incidents log. Such events, which are rare, are fully investigated with all lessons learned directly acted upon and monitored.

In our recent staff survey results 93 per cent of our staff felt able to report errors or incidents which can be seen as evidence of a positive reporting culture and supported learning environment within the trust.

In addition to these issues, grade 3 pressure ulcers were added to the list of reportable serious incidents in late 2011.

A full root cause analysis is undertaken for all serious incidents and never events and all actions and learning are monitored to prevent reoccurrence.

Friends and Family Test
Last year we took part in a regional pilot aimed at improving patient feedback called the Friends and Family Test, a simple questionnaire on discharge that asked 10 per cent of our patients whether they would recommend our hospital to their loved ones.

From April 2013 this test has gone nationwide and patients are now asked whether they would recommend not only the hospital wards but our A&E department to their friends and family if they needed similar care or treatment.

This is based around the question: “How likely are you to recommend our ward/department to friends and family if they needed similar care or treatment?” and means every patient in these wards and departments will have the opportunity to give feedback on the quality of the care they receive.

When the test was launched in April 2012 our net promoter score was 45, our latest score for March 2013 was 82, putting us in the top 20 per cent of trusts.

We are now required to receive feedback from at least 15 per cent of those discharged, and will continue to promote this vital mechanism for feedback with our patients.

Care Quality Commission (CQC) visits
The CQC visited the Trust in October 2012 as part of their routine schedule of planned inspections.

Commission inspectors toured the hospital, checking records, watching how services were delivered and speaking to both patients and staff.
Their checklist included Accident and Emergency, outpatients and paediatrics, as well as medical and surgical wards and the maternity unit.

A total of seven out of 16 outcomes were reviewed during their visit, and the Trust was found to be meeting the standard for all seven outcomes looked at, namely:

- **Outcome 2**: consent to care and treatment: (compliant) Before people are given any examination, care, treatment or support, they should be asked if they agree to it.

- **Outcome 4**: care and welfare of people who use services (compliant) People should get safe and appropriate care that meets their needs and supports their rights.

- **Outcome 6**: cooperating with other providers (compliant) People should get safe and coordinated care when they move between different services.

- **Outcome 9**: management of medicines (compliant) People should be given the medicines they need when they need them, and in a safe way.

- **Outcome 10**: safety and suitability of premises (compliant) People should be cared for in safe and accessible surroundings that support their health and welfare.

- **Outcome 14**: supporting workers (compliant) Staff should be properly trained and supervised and have the chance to develop and improve their skills.

- **Outcome 17**: complaints (complaint) People should have their complaints listened to and acted on properly.

The report additionally stated ‘patients told us that they were happy with how staff explained their care and treatment. They told us that everything was explained in a way which they could understand so that they could give their consent to the care and treatment they received’.

An internal CQC action plan has been developed in response to observations and potential areas for improvement noted by the CQC.

Implementation of the action plan is progressing well, and is internally monitored by the Trust’s governance unit.

**Local Clinical Audits**

The audit department continues to support local audit projects and there have been 285 audits registered on the corporate database for 2012/13. These represent a cross section of specialities from across the Trust.

The following summaries some of the key improvements that have been made following local audit

**Audiology - audit of ABR waveforms.**

The process has been reviewed and the protocol updated to include how we record rejected waveforms.

**Ear Nose and Throat - role of routine nasopharyngeal biopsy in adult secretory otitis media.**

Adoption of new departmental protocol for the management of adult patients with new on set secretory otitis media (glue ear)

**Pharmacy - drug prescription chart audit.**

The allergy status has been amended to guide the prescriber into completing all components and a “how to use the drug chart guide” has been implemented for doctors including how to cancel prescription record devices for insulin and recording their contact details.
**Oncology - pragmatic approach to EGFR mutation testing in advanced lung cancer.**
Improvement of successful tissue testing by increasing quantity and quality of biopsy. Early engagement and discussion with intervention radiologists and respiratory physicians need to take place and to reduce time delay of EGFR analysis early MDT discussion to identify patients who would benefit from testing and prompting early initiation of testing.

**Acute medicine – acute medical unit discharge summary audit.**
Discharge summaries to form part of work-placed assessments for all trainees and AMU discharge summary guidance to be written and distributed.

**Performance against 2012/13 key national priorities**

During 2012/13, the Trust continued to respond to the NHS operating framework.

The Trust continues to review the services that we provide, and the systems and processes that support them, in order to ensure that they are accessible to patients – Southend University Hospital NHS Foundation Trust recognises that providing timely access contributes to a positive patient experience.

The range of clinical outcome measures for which data is collated at Southend is currently undergoing review by the new medical director; a system put in place some two years ago, with data being collated on measures determined as important to the Trust’s data collated during the year for various measures is included here below. Items that appear with no details refer to items for which data has not been collected during the year.
### Clinical Outcome Measures 2012/13

<table>
<thead>
<tr>
<th>Business Unit</th>
<th>Speciality</th>
<th>Outcome Measure</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Latest Data Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Diagnostic &amp; Therapeutic</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Oncology</td>
<td>% Radiotherapy within 24hrs for Spinal Cord Compression Post MRI</td>
<td>100%</td>
<td>36.84%</td>
<td>40.00%</td>
<td>56.25%</td>
<td>55.00%</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td>Haematology</td>
<td>Full Blood Counts Reported on ICE Within 60 Minutes of Receipt From A&amp;E</td>
<td>&gt;95%</td>
<td>96.90%</td>
<td>97.49%</td>
<td>96.81%</td>
<td>-</td>
<td>December ’12</td>
</tr>
<tr>
<td></td>
<td>Pathology</td>
<td>Borderline Nuclear Abnormality Rates for Cervical Screening</td>
<td>&lt;9%</td>
<td>8.13%</td>
<td>9.93%</td>
<td>8.70%</td>
<td>8.56%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average SDI Rate for Liver, Testicular and Ovarian Tumour Marker (AFP)</td>
<td>-2. to +2.</td>
<td>-0.698</td>
<td>-0.033</td>
<td>-0.916</td>
<td>-0.491</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average SDI Rate for Molar, Testicular and Ovarian Tumour Marker (HCG)</td>
<td>-2. to +2.</td>
<td>-0.242</td>
<td>0.196</td>
<td>-0.281</td>
<td>-0.673</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average SDI Rate for Prostate Tumour Marker (PSA)</td>
<td>-2. to +2.</td>
<td>-</td>
<td>0.923</td>
<td>0.330</td>
<td>0.703</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average SDI Rate for GI Tract Tumour Marker (CEA)</td>
<td>-2. to +2.</td>
<td>0.287</td>
<td>0.620</td>
<td>0.454</td>
<td>-0.290</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average SDI Rate for Ovarian Tumour Marker (CA125)</td>
<td>-2. to +2.</td>
<td>-1.493</td>
<td>-0.651</td>
<td>-0.158</td>
<td>-0.300</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average SDI Rate for Pancreatic Tumour Marker (C199)</td>
<td>-2. to +2.</td>
<td>0.155</td>
<td>-0.043</td>
<td>-0.134</td>
<td>-0.205</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td>Lung Cancer</td>
<td>Patients with Small Cell Lung Cancer Chemotherapy Rate</td>
<td>&gt;60%</td>
<td>100.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td>Accident &amp; Emergency</td>
<td>Door to Needle Time (% within 1hr - for Neutropenic Patients)</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Missed Fracture Rate</td>
<td>&lt;5%</td>
<td>0.36%</td>
<td>0.20%</td>
<td>0.23%</td>
<td>0.20%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Unscheduled Reattendances Within 7 Days</td>
<td>&lt;5%</td>
<td>5.69%</td>
<td>5.74%</td>
<td>5.86%</td>
<td>6.11%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td>Medicine</td>
<td>MI Patients Discharged on Secondary Prevention</td>
<td>&gt;80%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rapid Access Chest Pain (% Seen Within 14 Days)</td>
<td>&gt;98%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td>DME</td>
<td>Patients Aged &gt;75 To Have Cognitive Assessment Within 72 Hrs of Non-Elective Admission</td>
<td>&gt;90%</td>
<td>-</td>
<td>90.45%</td>
<td>93.28%</td>
<td>91.65%</td>
<td>February ’13</td>
</tr>
<tr>
<td>Business Unit</td>
<td>Speciality</td>
<td>Outcome Measure</td>
<td>Target</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Latest Data Received</td>
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<tr>
<td></td>
<td>Stroke</td>
<td>Death Rate Following A Stroke</td>
<td>8%</td>
<td>14.20%</td>
<td>11.35%</td>
<td>14.53%</td>
<td>9.91%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of Patients who Return Home with Total Independence</td>
<td>&gt;50%</td>
<td>46.47%</td>
<td>59.43%</td>
<td>56.50%</td>
<td>50.82%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remain In the Top 25% of the National Sentinel Stroke Audit</td>
<td>Top 25%</td>
<td>10.60%</td>
<td></td>
<td></td>
<td></td>
<td>March ’13</td>
</tr>
<tr>
<td>Medicine</td>
<td>Sexual Health</td>
<td>% New Patients Offered a GUM Appt within 48hrs</td>
<td>&gt;98%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% First Attendances Seen Within 48hrs</td>
<td>&gt;85%</td>
<td>97.81%</td>
<td>97.84%</td>
<td>97.84%</td>
<td>97.60%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Uptake of HIV Test by New and Rebook Patients</td>
<td>&gt;60%</td>
<td>66.95%</td>
<td>67.58%</td>
<td>70.49%</td>
<td>71.72%</td>
<td>February ’13</td>
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<tr>
<td></td>
<td>Palliative Medicine</td>
<td>Number of Patients who Have an Expected Death in Hospital Using the Care Pathway</td>
<td>Basic Rate</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred Priorities of Care And the Recording of Advance Care Plan</td>
<td>TBC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Renal</td>
<td>MRSA Rates for Patients Undergoing Dialysis</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survival Rates After 90 Days of Haemodialysis</td>
<td>TBC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Respiratory Med.</td>
<td>Non Small Cell Lung Cancer Curative Surgical Resection Rates</td>
<td>&gt;10%</td>
<td>45.24%</td>
<td>20.00%</td>
<td>28.89%</td>
<td>12.50%</td>
<td>February ’13</td>
</tr>
<tr>
<td></td>
<td>Rheumatology</td>
<td>Proportion of New RA Remission/Low Disease Activity State at 6mths</td>
<td>&gt;60%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of RA with Good/Moderate Euler Response at 6mths</td>
<td>&gt;60%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MSK</td>
<td>Trauma &amp; Orthopaedics</td>
<td>% Elective Patients Requiring 2nd Op Post Joint Replacement Surg</td>
<td>&lt;6%</td>
<td>0.45%</td>
<td>0.46%</td>
<td>0.49%</td>
<td>0.51%</td>
<td>March ’13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Patients with Hip Fractures Operated on within 36hrs</td>
<td>&gt;80%</td>
<td>72.04%</td>
<td>90.48%</td>
<td>-</td>
<td>-</td>
<td>July ’12</td>
</tr>
<tr>
<td></td>
<td>Ophthalmology</td>
<td>Cataract Surgery - Posterior Capsule Rupture Rate</td>
<td>&lt;2%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vitreo-Retinal Surgery - Macular Hole Closure Rate</td>
<td>&gt;80%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Business Unit</td>
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<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
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<tr>
<td></td>
<td>ENT</td>
<td>% Daycase Transferred to Centre</td>
<td>&lt;90%</td>
<td>1.83%</td>
<td>0.00%</td>
<td>0.41%</td>
<td>0.00%</td>
<td>March '13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Daycase Admitted Overnight</td>
<td>&lt;90%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>March '13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Return to Theatre Rate</td>
<td>&lt;1.5%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td>General Surgery</td>
<td>Unplanned Return to Operation Theatre</td>
<td>&lt;5%</td>
<td>3.06%</td>
<td>3.57%</td>
<td>2.57%</td>
<td>2.74%</td>
<td>March '13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgical Site Infections After 'Clean Operations'</td>
<td>&lt;2%</td>
<td>1.26%</td>
<td>0.77%</td>
<td>1.44%</td>
<td>0.25%</td>
<td>March '13</td>
</tr>
<tr>
<td></td>
<td>Oral Surgery</td>
<td>Return to Theatre Rate</td>
<td>&lt;1.5%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of Unscheduled/Emergency Return Visits (Following OP)</td>
<td>&lt;4%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthodontics</td>
<td>Par Score Changes</td>
<td>&gt;70%</td>
<td>91.50%</td>
<td>91.75%</td>
<td>90.67%</td>
<td>92.38%</td>
<td>February '13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiographic Changes</td>
<td>&gt;5</td>
<td>6.14</td>
<td>6.00</td>
<td>5.89</td>
<td>5.67</td>
<td>February '13</td>
</tr>
<tr>
<td></td>
<td>Urology</td>
<td>% OP Patients Seen and Discharged in a Single Visit i.e. One Stop</td>
<td>&gt;85%</td>
<td>67.03%</td>
<td>63.21%</td>
<td>60.44%</td>
<td>50.56%</td>
<td>March '13</td>
</tr>
<tr>
<td>Obstetrics - Fetal</td>
<td>Colposcopy</td>
<td>% Evidence of CIN on Histology when Treated at 1st Visit</td>
<td>&gt;90%</td>
<td>96.72%</td>
<td>91.84%</td>
<td>96.30%</td>
<td>97.67%</td>
<td>March '13</td>
</tr>
<tr>
<td>Obstetrics - Maternal</td>
<td>Obstetrics</td>
<td>Perinatal Mortality Rate</td>
<td>&lt;5.6/1000</td>
<td>1.02</td>
<td>2.96</td>
<td>0.96</td>
<td>7.07</td>
<td>January '13</td>
</tr>
<tr>
<td>Obstetrics - Maternal</td>
<td>Obstetrics</td>
<td>Still Birth Rate</td>
<td>&lt;3.1/1000</td>
<td>3.05</td>
<td>2.96</td>
<td>4.82</td>
<td>7.07</td>
<td>January '13</td>
</tr>
<tr>
<td>Paediatrics</td>
<td></td>
<td>3rd Degree Tear</td>
<td>&lt;5%</td>
<td>2.15%</td>
<td>1.98%</td>
<td>2.30%</td>
<td>2.11%</td>
<td>January '13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of Massive PPH &gt; 2000ml</td>
<td>&lt;5</td>
<td>4.00</td>
<td>4.67</td>
<td>3.33</td>
<td>2.00</td>
<td>January '13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combined National Audit of Neonatal Mortality with Morbidity</td>
<td>07/08 Baseline</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HbA1c in Children and Adolescence with Type 1 Diabetes</td>
<td>&lt;8.5%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
Other information

The trust must provide a copy of the draft Quality Account to the clinical commissioning group which has responsibility for the largest number of persons to whom the provider has provided relevant health services during the reporting period for comment prior to publication and we include these comments as follows.

Annexes:

Comments (obligatory) from commissioners  
Comments (voluntary) from Southend – Borough Council (OSC)  
Comments - from Governors’ Patient and Carer Experience Group -  
Statement of Directors’ Responsibilities in respect of the Quality Account  
Independent Auditors’ Report to the Council of Governors of Southend University Hospital NHS Foundation Trust on the Quality Account
NHS Southend CCG commentary on Southend University Hospitals NHS Foundation Trust

NHS Southend Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the fourth annual Quality Account prepared by Southend University Hospitals NHS Foundation Trust (SUHFT) as the coordinating commissioner of the Trust’s services. It is to be noted that this response is made on behalf of the four CCGs in South Essex, Castle Point and Rochford CCG, Basildon and Brentwood CCG and Thurrock CCG. Following the dissolution of the Primary Care Trusts from 1 April 2013 any monitoring and assurances for the quality of services provided in Southend Hospital will be undertaken by NHS Southend CCG.

To the best of NHS Southend CCG’s knowledge, the information contained in the Account is accurate and reflects a true and balanced description of the quality of provision of services.

NHS Southend CCG notes the strong priorities for patient safety and clinical effectiveness for 2013/14. They include the provision of nutritional assessment of patients on admission; optimising the recognition and treatment of the deteriorating patient and it is noted that the Trust will be conducting Executive Safety Walkabouts. NHS Southend CCG will be seeking assurance of compliance with all of the above safety initiatives through the CCGs’ membership on the Trusts Clinical Assurance Committee and through the formal Clinical Quality Review Group meetings held monthly with the Trust. In addition the CCG will coordinate its own quality improvement visits to ensure standards are maintained in the Trust.

The CCG is in support of the Clinical Effectiveness priorities which include the identification of patients with suspected dementia and the CCG is working closely with the Trust to ensure effective communication with the patients’ GP in the diagnosis of dementia.

Operational targets include compliance with the sixty-two day cancer wait, referral to treatment times and the 95% compliance with the four hour accident and emergency target. The CCG has noted that the Trust has failed to achieve both of these targets during 2012/13 and the Trust has developed a rectification plan to ensure delivery of these key areas of patient care.

NHS Southend CCG will continue to seek assurance relating to the measurement of Standard Hospital Mortality Indices (SHMI) which continues to be a quality indicator for 2013/14 to ensure sustained compliance. The Trust position has been within expected limits and the CCG is aware of the scrutiny that the Trust continues to apply to this indicator. This is monitored through the quality monitoring process and the CCG will expect the Trust to work towards continued improvement of the Indicator and to give early indication of any concerns.

All of the above priorities are of great significance in the current climate within the NHS following the publication of the reports following the inquiries into the Winterbourne View and Mid Staffordshire Hospital.

NHS Southend CCG was pleased to note the actions taken following participation with the national clinical audit programme and will ensure during 2013/14 that actions have been fully implemented to enhance patient safety, experience and quality of care.

The Quality Account 2011/12 noted that an audit of theatre practice and the surgical check list would be undertaken during 2012/13. Whilst NHS Southend CCG is aware of its completion the results are not included within this Account. This would be of particular importance as the Trust has reported four Never Event serious incidents during this period. Following these events the CCG reviewed the areas where the incidents occurred to seek assurance of actions being taken. The CCG continues to seek assurances relating to all serious incidents by reviewing all investigation reports and the monitoring of all actions taken to improve patient safety and quality of services.
The CCG welcomes the ‘Have your say’ initiative in the Trust which allows staff to raise any concerns that they may have in confidence.

The Trust’s performance against 2012/13 priorities included the reduction in healthcare associated infections, NHS Southend CCG note that the Trust breached their trajectory of no more than one case of MRSA as there were three reported events, each incident resulting in a full root cause analysis. To ensure robust monitoring of lessons learned and to reduce further incidents, NHS Southend CCG will be seeking assurances through continued scrutiny of delivery of the action plans and the embedding of learning, in the light of the new national requirement for zero tolerance for MRSA Bacteraemia.

NHS Southend CCG congratulates the Trust on the below target achievement for CDifficile incidence, whilst recognising the challenging target for 2013/14.

In the 2011/12 Account the patient revolution friends and family initiatives were to be developed and embedded and NHS Southend CCG are pleased to note that patients’ feedback has improved during 2012/13, with SUHFT being within the top 20% of Trusts.

The Account reports that the Trust is registered with the CQC and there was one inspection in October 2012, as part of the CQC’s routine schedule. Seven outcomes were reviewed and note that full compliance was reported. NHS Southend CCG will seek assurances that any actions that arose from this inspection are completed and will continue to seek assurances throughout 2013/14 of compliance with the outcomes.

The CCG recognises that the Trust’s performance in Maternity services was not at the required level and was supportive of the Trust undertaking a review of the Maternity Services in the Hospital. Following the review the Trust has developed a comprehensive action plan to improve the quality and safety of services. The implementation of the action plan is being closely monitored within the Trusts and also by the CCG through the Clinical Quality review Group.

NHS Southend CCG continues to meet regularly with SUHFT to seek assurance that quality, patient safety and experience is reported and monitored. The CCG formally challenge SUHFT on any areas of concern but also provide support in order for improvements in patient care to be made. Assurances on the quality of service provision will also be monitored through a programme of announced and unannounced visits to strengthen quality assurance processes to observe in real time the delivery of patient care.

The outcome of these visits and all monitoring of safety, service quality and patient experience are reported back to the Trust and also to the CCG Governing Body.

NHS Southend CCG is fully supportive of all the priorities identified by SUHFT in taking forward the patient safety, effectiveness, experience and involvement agenda and looks forward to working in partnership with the Trust in the forthcoming year.

Dr B Agha
Chair
NHS Southend Clinical Commissioning Group
Southend-on-Sea Borough Council
Department for Corporate Services
John Williams - Head of Legal & Democratic Services

Our ref:  
Your ref: fa  
Date: 20th May 2013  
Contact Name: F Abbott

Jacqueline Totterdell  
Chief Executive  
Southend University Hospital NHS Foundation Trust  
Prittlewell Chase  
Westcliff-on-Sea  
Essex  
SS0 0RY

Dear Ms Totterdell,

Quality Account 2012/13

Thank you for sending the draft Hospital Quality Account 2012/13.

I have shared the document with the Chairman and Vice Chairman of the People Scrutiny Committee at Southend and have agreed that our response will be:

In view of the timescales for submitting comments on the Quality Account for 2012/13, we wish to advise you that the People Scrutiny Committee will not be submitting a response. This should in no way be taken as a negative comment on the hard work and achievements of your organisation over the past year.

Yours sincerely

Fiona Abbott  
Principal Committee officer

Cc Councillor Alex Kaye, Chairman, People Scrutiny Committee; Councillor Mark Flewitt, Vice Chairman, People Scrutiny Committee
Feedback from Governors’ Patient and Carer Experience Group

This comprehensive report is clearly laid out and accessible to the general reader. While there is much less repetition than in previous years, seeing the same information, referring to the 62 day target for cancer waits, produced verbatim under Performance against 2012/13 priorities, and again under Clinical effectiveness priorities 2013/14 is irritating.

Governors welcome the improvements which have been made in the last 12 months thanks to the commitment and hard work of staff at all levels in the organisation, not forgetting our willing volunteers. The Trust is not complacent and acknowledges the need to strive for excellence. We were especially pleased that the Trust met the challenging target for the reduction in C-Diff cases, but are aware that the coming year will be even more difficult. The measures taken to increase the numbers for Nutrition assessment on admission have paid dividends and we are glad that this will continue as a priority in the coming year. Governors will want to know more about why some patients have not been assessed; whether there is a variety of reasons or themes that could be addressed.

The priorities for 2013-2014 have been shared with Governors. We understand that delays in Accident and Emergency Departments are a nation-wide problem, and not all of our own making. The emphasis on Quality at Board meetings has been apparent to Governors in attendance. The quarterly patient story is proving to be a worthwhile addition to the Agenda, as have the monthly presentations to the Hospital Heroes nominated by their colleagues for making a difference and going beyond the call of duty.

Governors will be involved in the new Patient and Carer Focus Group. Already they have contributed to the Carers’ strategy.

We were pleased with the response from the Care Quality Commission after their inspection in October 2012, but realise that we must continue to be vigilant and listen carefully to what the members of the Foundation Trust and the public tell us of their experiences, both the positive and where we can improve.

Elaine Blatchford
Chair of the Governors’ Patient and Carer Experience Group.

15 May 2013
Statement of directors’ responsibilities in respect of the Quality Account

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.

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

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 2012/13;
- the content of the quality account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to May 2013
  - Papers relating to quality reported to the board over the period April 2012 to May 2013
  - Feedback from the commissioners dated 29/05/2013
  - Feedback from governors dated 15/05/2013
  - Feedback from Local Healthwatch organisations – not received
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/04/2013
  - The National Inpatient Survey 16/04/2013
  - The National Staff Survey 28/02/2013
  - The head of internal audit’s annual opinion over the Trust’s control environment dated 24/05/2013
  - CQC quality and risk profiles dated October 2012 – February 2013
- the quality account presents a balanced picture of the NHS foundation 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; and the quality account has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the quality accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality account (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

Alan Tobias, OBE
Chairman
28 May 2013

Jacqueline Totterdell
Chief Executive
28 May 201
Independent Auditors’ Report to the Board of Governors of Southend University Hospital NHS Foundation Trust on the Quality Account

We have been engaged by the Board of Governors of Southend University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Southend University Hospital NHS Foundation Trust’s Quality Account for the year ended 31 March 2013 (the “Quality Account”) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C. Difficile (reported on page 52 and 75)
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers (reported on page 52)

We refer to these national priority indicators collectively as the “indicators”.

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Account in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Account is not consistent in all material respects with the sources specified below; 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 NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Accounts.

We read the Quality Account and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to 30 May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to 30 May 2013;
- Feedback from the Commissioners dated 29/05/2013;
- Feedback from local Healthwatch organisations (not received);
- The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/04/2013;
- The national inpatient survey dated 16/04/2013;
- The national staff survey dated 28/02/2013;
- Care Quality Commission quality and risk profiles dated October 2012 to February 2013;
- The Head of Internal Audit’s annual opinion over the trust’s control environment dated 24/05/2013; and
- Any other information included in our review.
We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those 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.

This report, including the conclusion, has been prepared solely for the Council of Governors of Southend University Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Southend University Hospital NHS Foundation Trust’s quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate 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 Council of Governors as a body and Southend University Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Account.
- Reading the documents.

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

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

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

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Southend University Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Account is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Ernst & Young
Ernst & Young LLP
Cambridge
29 May 2013
Glossary

The list below highlights the essential services which form part of the Trust’s contracts.

General surgery
Urology
Trauma and orthopaedics
Ear, nose and throat (ENT)
Oral surgery
Orthodontics
Accident and Emergency (A&E)
(Intensive treatment unit
(High dependency unit
General medicine
Gastroenterology
Endocrinology
Clinical haematology
Pathology
Palliative medicine
Cardiology
Dermatology
Neurology
Clinical neuro-physiology
Rheumatology
Paediatrics/SCBU
Geriatric medicine
Obstetrics
Gynaecology
Clinical oncology (previously Radiology)
Radiology

Histopathology
Pain management
Clinical microbiology
Neonatology
Diabetic medicine
Elderly medicine
Oncology
Ophthalmology
Respiratory medicine
Sleep studies
GU medicine
Paediatrics
Paediatric cardiology
Paediatric endocrinology
Paediatric gastroenterology
Paediatric respiratory medicine
Neurosurgery
Level 1, 2 and 3 neo-natal intensive care (three separate services)
Radiotherapy
Chronic Fatigue Syndrome/ Myalgic Encephalopathy (ME)
Staff nursery
Sexual health clinics
Neuchal screening
Step Down for discharge
HDU for respiratory medicine
Private patients
Rehabilitation
BUD – Business unit director
CAC – Clinical assurance committee
Care bundle – check list with a number of points to be monitored on a regular basis
C-diff – Clostridium difficile
CEMACE – Centre for Maternal and Child Enquiries
CEMACH – Confidential Enquiry into Maternal and Child Health
CETV – Cash equivalent transfer value
CIP – Cost improvement programme
CLRN – Comprehensive local research network
CNS - Clinical nurse specialist
CNST – Clinical Negligence Scheme for Trusts
COPD – Chronic obstructive pulmonary disease
Core brief – Monthly meeting designed to cascade important information throughout the organisation
CQC – Care Quality Commission
CQUIN – Commissioning for quality and innovation – a financial reward framework which encourages quality improvement and innovation to bring health gains for patients, eg achieving reduced levels of infection
DAHNO - Data for Head and Neck Oncology
Dashboard – Dashboard reports are high level, easy to read reports giving a ‘snapshot’ of the overall performance of an organisation, department or chosen area
DIPC – Director of infection prevention and control
DVT – Deep vein thrombosis
EBITDA – Earnings before interest, taxes, depreciation and amortisation
EDS – Equality delivery system
EML – Enterprise Medical Limited
EoE SHA – East of England Strategic Health Authority
EPP - Emergency patient pathway
Executive team – The Trust’s chief executive, director of nursing, director of finance, medical director, director of strategic development, director of operations and director of human resources
FRR – Financial risk rating
FT – Foundation Trust
GDH - Glutamate Dehydrogenase
Grade 3 pressure ulcer – Full thickness skin loss
Grade 4 pressure ulcer – Extensive destruction with possible damage to muscle, bone or supporting tissues
GRR – Governance risk rating
HCA – Healthcare assistant
HCAI – Healthcare associated infection
HMSR – Hospital standardised mortality ratio (relative risk of death)
HROD – Human resources organisational development
ICNARC – Intensive Care National Audit and Research Centre
IOSH – Institute of Occupational Safety and Health
IP – Intellectual property
KPI – Key performance indicator
LD – Learning disabilities
LiNks – Local involvement networks
MHRA – Medicines and Healthcare products Regulatory Agency
Monitor – The organisation which authorises and regulates NHS Foundation Trusts
MRI – Magnetic resonance imaging (a type of scan)
MRSA – Meticillin-resistant staphylococcus aureus
MSSA – Meticillin-sensitive staphylococcus aureus
NAS – Neonatal abstinence syndrome
NHS LA – NHS Litigation Authority
NICE – National Institute for Health and Clinical Excellence
NIHR – National Institute for Health Research
NIV – Non-invasive ventilation
NPEU – National Perinatal Epidemiology Unit.
NPSA – National Patient Safety Agency
O&G – Obstetrics and gynaecology
OH – Occupational health
OPD – Outpatients department
PALS – Patient advice and liaison service
PDSA – Plan, do, study, assess
PET – Positron emission tomography, or patient experience tracker
PMO – Project management office
PPH – Post-partum haemorrhage
PROMS – Patient-reported outcome measures
QAC – Quality assurance committee
QIPP – Quality, Innovation, Productivity and Prevention (now called System Reform)
QRP – Quality and risk profile
RCA – Root cause analysis
RCOG – Royal College of Obstetricians and Gynaecologists
RTT – Referral to treatment
SEPT – South Essex Partnership University NHS Foundation Trust
SFI – Standing financial instruction
SHMI – Summary Hospital-level Mortality Indicators report mortality at trust level across the NHS in England using standard and transparent methodology
SHOT – Serious hazards of transfusion
TDM – Therapeutic drug monitoring
TIA – Transient ischaemic attack