Southend University Hospital NHS Foundation Trust
Quality Account 2013 - 2014

This account was approved by the board of directors on 27 May 2014

Cover photograph entitled Everyone’s responsible, taken by Zoe Littlefield and Holly Matthews as part of a community project with photography students from South Essex College to demonstrate the trust’s values of Everybody matters, Everything counts, Everyone’s responsible.
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 2013/14, and details of the priorities set for the coming year.

In part two, there are also 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
Contents

Part 1:
Statement on quality from the Chief Executive 7

Part 2:
Our chosen priorities for 2014/15 9
Progress made since publication of the 2012/13 report 13
Statements of assurance from the board of directors 22
Reporting against core indicators - information provided by the Health and Social Care Information Centre 30

Part 3:
Other information:-
Embedding quality at Southend University Hospital 41
Performance against 2013/14 key national priorities 49

Annexes:
Feedback from Southend Clinical Commissioning Group 56
Feedback from the local Healthwatch 58
Feedback from the local Overview and Scrutiny Committee (Council) 60
Feedback from governors 61
Statement of directors’ responsibilities in respect of the Quality Account 62
Auditors’ limited assurance report 63
statement on quality from the chief executive

Welcome to our quality account 2013/14, 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.

I know from my interactions with staff at all levels that they are totally committed to providing excellent care for our patients and are firm in the belief that ‘everybody matters, everything counts, everyone’s responsible’.

Nevertheless, we all know that the NHS is facing one of the most challenging periods ever. Following the Francis Report and the Keogh Review, the quality of care in hospitals has rightly been in the spotlight.

The last year has undoubtedly presented a number of challenges. The number of patients using our emergency services has increased in recent months and we have struggled to meet the required target of a maximum four-hour wait. Internally we have met our target of 85% to see and treat all patients with cancer within 62 days; however for those patients referred externally we have not been compliant with the 62-day ceiling. In both cases, we have invited in external assistance from the national intensive support team to help us utilise best practice from other hospitals, and have produced robust action plans to address performance issues which will be monitored throughout the year by the Trust board.

Our priorities for 2014/15, which we established following consultation with staff, governors and members of the public, will be:

Patient Safety
- World Health Organisation (WHO) checklist
- Early Warning System
- Duty of Candour.

Patient Experience
- Patient Feedback
- Patient Focus Groups
- Education and development programmes for staff at all levels.

Clinical Effectiveness
- Ensure nursing skill mix is safe and appropriate to caseload
- 62-day ceiling for cancer waits
- 4-hour accident and emergency target.

Poor patient nutrition and care in hospital has been a national focus once again this year but it is an area where we have made a number of improvements. These include ensuring all new patients are given a nutritional risk assessment on admission and reviewing our catering contract.

Over 200 patient safety walkabouts took place this year and they have been an important tool for the trust board and council of governors to witness first-hand some of the excellent work that takes place on the wards. It has also proved very popular with front-line staff and has identified a number of areas for improvement, which we have acted upon immediately.

Our current registration status with the CQC is unconditional and the Commission has not taken any enforcement action against the Trust during 2013/14. However, following a CQC visit in May 2013, the Trust was found to be non-compliant with six of eight outcomes assessed. A subsequent action plan was devised and implemented to remedy areas of poor practice identified.
A second inspection was undertaken by the CQC in October 2013 to assess whether the Trust had been successful in addressing concerns identified during the first inspection. The CQC found the Trust to be compliant with all six outcomes assessed.

We routinely take part in national clinical audits as well as designing and undertaking local audits. This process helps us identify what works well in the delivery of clinical care, what we need to change and whether we have met the standards which were set for us nationally. Using these findings, we will keep striving to improve and refine during the coming year.

The financial pressures and uncertainties surround the NHS reforms will be present again during the coming year. But it will continue to be our mission to work with our colleagues in the Clinical Commissioning Groups to strive for quality whilst delivering the efficiencies needed.

I hope the following pages give you a sense of our 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
May 2014
Part Two

Priorities for Improvement for 2014/15:

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.

This year we held a week-long road show around the hospital to gain insight into staff, patient and public concerns, and all had the opportunity to vote on what was important to them. Different things matter more to different stakeholder groups but the three top priorities were very clear: to continue to reduce avoidable deaths (78%), to ensure the nursing skill mix is safe and appropriate to caseload (68%) and to provide a positive patient experience (74%).

We also involved our governors using an existing network of governor-led bi-monthly public meetings, patient and carer forums, and listening exercises.

Patient Safety Priorities 2014/15

To continue to reduce avoidable deaths, a key priority identified by our staff and public, the following indicators were selected:

World Health Organisation (WHO) checklist

Why we have chosen this priority?
We want to ensure that our patients are cared for safely throughout their surgery and a critical part of this is to have compliance with the WHO checklist before, during and after surgery.

How will we improve?
We will carry out monthly audits on our compliance with the WHO checklist and act on any shortfalls in practice.

How will we measure our improvement and what are our targets?
Our target is for 100% of applicable surgical patients to undergo a comprehensive safety checklist that incorporates all the elements of the WHO initiative.

How will we report and monitor our progress?
Our progress will be reported through the business unit’s governance meeting then onward to the clinical assurance committee though their business unit’s quarterly reports. This is then reported up to the quality assurance committee through the quality account updates. Any issues will be escalated to the Trust board via the quality assurance committee chair’s report.

Early warning system

Why we have chosen this priority?
Early recognition of the deteriorating patient is critical to be able to intervene rapidly and effectively to avoid harm to our patients.

How will we improve?
We will undertake a comprehensive review of the use of our early warning system and escalation procedures for deteriorating, high-risk patients, in particular at weekends and out of hours.

How will we measure our improvement and what are our targets?
We will continue to audit our performance on the recognition of the deteriorating patient through the critical care outreach team. This will be undertaken monthly and it is our intention that we achieve 100% compliance with patients that meet the criteria to be escalated.

How will we report and monitor our progress?
Compliance will be reported to the Trust resuscitation committee bi-monthly. Issues with compliance will be escalated to both the clinical assurance committee and the quality assurance committee. Any issues will be escalated to the Trust board via the quality assurance committee chair’s report.
Duty of candour

Why we have chosen this priority?
We know through feedback from our patients and carers that when things go wrong it is important to them that we are open and honest regarding what has happened (duty of candour).

How will we improve?
We will baseline the number of serious incidents and critical incidents that we reported in the year 2013/14 and, from this, look at ways that we are able to ensure that we have systems in place to ensure transparency with our duty of candour.

How will we measure our improvement and what are our targets?
We will measure our compliance that we are being open and honest when things go wrong through our serious and critical incident reporting. Our target set with our commissioners is that in 85% of cases we undertake this.

How will we report and monitor our progress?
Our progress will be monitored through bi-monthly reports that are taken to the quality assurance committee regarding serious incidents. Any issues will be escalated to the Trust board via the quality assurance committee chair’s report.

Patient Experience Priorities 2014/15
Provide a positive patient experience

Patient feedback

Why we have chosen this priority?
We know that the very best consumer-focused organisations embrace feedback, concerns and complaints from their customers as a powerful source of information for improvement.

How will we improve?
We will take a cohesive approach to real-time patient feedback ensuring that we know what our patients feel about their care at the point of care in addition to the Friends and Family test; we will act on the comments and suggestions from our patients at a local level ensuring that staff and patients are aware of feedback, utilising the “you said, we did” slogan throughout the Trust. We will also update our comments cards to reflect this by asking our patients “what did we do well?” and “what could we have done better?” to further embed this practice.

How will we measure our improvement and what are our targets?
We will report to the clinical assurance committee questions from the patient trackers that are managed by each of the business units and monitor the changes in practice through this committee.

How will we report and monitor our progress?
We will have in place in all clinical areas “you said, we did” boards following our patients’ feedback which will be reported to the clinical assurance committee.

Patient focus groups

Why we have chosen this priority?
We want to ensure that future developments within the organisation have input from patient and public engagement and by seeking the views of patients and the public through focus groups both Trust-wide and in each of the business units.
How will we improve?
We set out in 2013/14 to have focus groups in place in each of the business units reporting into a Trust-wide group. Since this was not fully achieved in the past year, we have kept this as a priority for the forthcoming year. We will seek to have all of these groups in place over the forthcoming year.

How will we measure our improvement and what are our targets?
We will ensure that each business unit establishes a focus group and/or monitors existing groups and records are kept of the number of meetings each year. Feedback and consultation from the meetings in relation to future developments will be reported to the Trust-wide group.

How will we report and monitor our progress?
The Trust forum will report regularly to the quality assurance committee (QAC) with outcomes and action plans.

Education and development programmes for all levels of staff

Why we have chosen this priority?
We know that staff who engage with the Trust’s values will reflect these elements in their practice, thus providing a better patient experience.

How will we improve?
We will develop and implement education and development programmes for all levels of staff based on our values.

How will we measure our improvement and what are our targets?
We will measure how these are reflected in practice through the feedback from our patients utilising the national in-patient survey, Friends & Family test and through the patient experience trackers.

How will we report and monitor our progress?
Friends & Family test results will be triangulated with quarterly feedback from patient experience trackers and when available through the national in-patient survey and reported to the quality assurance committee.

We will also report on the number of education sessions held that reflect our values.

Clinical effectiveness priorities 2014/15

Ensure nursing skill mix is safe and appropriate to caseload

Why we have chosen this priority?
We know that safe care can only be delivered when there are appropriate levels of staffing with the right skills.

How will we improve?
The Board will continue to sign off and publish evidence-based staffing levels at least every six weeks, providing assurance about the impact on quality of care and patient experience.

The Trust will display in each clinical area the approved establishment and actual staffing levels and monitor these through the integrated performance dashboard reported to the Trust board.

Where staffing levels are below optimum in the short term, a risk assessment will be undertaken and reported to the business unit director / associate business unit director for their actions. Where there are on-going staffing issues, an action plan will be put in place.

How will we measure our improvement and what are our targets?
Staffing levels will continue to be monitored through the Trust board. Staffing levels will be displayed in clinical areas and on the website. Action plans will be put in place where staffing is below optimum.
Due to the continued review of the appropriateness of our staffing levels, these will be reported on a monthly basis with the compliance achieved for each ward.

**How will we report and monitor our progress?**
Staffing levels are reported each month to the Trust board.

**62-day target for cancer waits**

**Why we have chosen this priority?**
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.

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 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 within 62 days 85% of patients who are directly referred to us rather than via a neighbouring trust, 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% of patients to begin treatment within 62 days of referral.

**Four-hour accident and emergency target**

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

We also recognise the importance for our patients in 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.

**How will we measure our improvement and what are our targets?**
The national target for compliance is 95% 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 Trust board.
Part two: Progress made since the previous report

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 nutrition which has been an indicator from 2011/12. The work on the assessment of patients and meeting their nutritional needs has been significant and the Trust views this as ‘business as usual’.

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 was this priority chosen?
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 therefore chose to continue to focus on this in recognition of the impact nutrition has on how patients feel and respond to treatment.

What we set out to do
We 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 expanded our snack round pilot project to more areas and continued to promote the work of our volunteer Feeding Buddies.

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

How did we measure our improvement and what were our targets?
A monthly clinical audit is undertaken by the matrons and includes aspects of ongoing assessment of nutritional risk, monitoring and referral to a dietician if required. Ward teams are then able to identify areas that can be improved further.

How we reported and monitored our progress throughout the year
The target for compliance with the nutritional assessment is 90%. This is reported monthly to Trust Board and at the professional nursing and midwifery forum.

2013/14 performance against previous years
The overall average compliance for the Trust undertaking a nutritional assessment against the questions asked is shown in the nutritional assessment performance graph below.
Recognition of the deteriorating patient

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

What we set out to do
To conduct regular audits to ensure compliance with our target and any actions identified and monitored within individual business units.

How did we measure our improvement and what were our targets?
We set a target of 85% compliance against the planned frequency of monitoring vital signs, used the early warning system and took actions to minimise or prevent further deterioration of patients.

How we reported and monitored our progress throughout the year
We reported through a Commissioning for Quality and Innovation (CQUIN) project. The aim was to reduce avoidable deterioration and improve the management of acutely ill patients.

We completed quarterly assessments of milestones, with RAG rating of progress. These were reported by the CQUIN project team to the resuscitation committee and to the Trust board.

We also sampled at least 20 patients’ observation charts each month. We looked at the completeness of recording vital signs (as NICE CG50 standard). The results of these audits are now being reported to the wards concerned and the matron.

2013/14 performance
- Currently working towards the introduction of ‘Ceilings of Care’ documentation for all acute medical admissions
- Piloted our single parameter early warning system against the national early warning system
- Introduction of multi-professional simulation training to enhance patient safety
- Piloted an audit tool to evaluate cardiac arrests outside A&E and developed structured feedback to patients’ primary team. Findings reported to the resuscitation committee
- Completed SBAR communication training to all wards and incorporated SBAR teaching in mandatory CPR (cardio-pulmonary resuscitation) training. SBAR (Situation, Background, Assessment, Recommendation) is a standardised way of communicating. It promotes patient safety because it helps individuals communicate with each other with a shared set of expectations. Staff and physicians can use SBAR to share patient information in a concise and structured format. It improves efficiency and accuracy.

Board safety walkabouts

Why did we choose this priority?
We have chosen to continue the work introduced on this measure from last year.

Patient safety walk rounds are a way of ensuring that the corporate team are informed first-hand about the safety concerns of frontline staff. They are also a way of demonstrating commitment by listening to and supporting staff when issues of safety are raised. Walk rounds can be instrumental in developing an open culture where the safety of patients is seen as the priority of the organisation.
What we set out to do
We will see an increased compliance with our key targets outlined earlier, in particular actions identified 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 seek to extend the walkabout team to include members of our council of governors, further promoting a culture of openness and transparency.

How did we measure our improvement and what were our targets?
During 2013/14 a total of 196 walkabouts by executive directors, non-executive directors and governors – accompanied by a matron from the relevant business unit – took place.

Twenty were postponed for various reasons, the Trust being under additional pressures from meetings that took priority and staff sickness; but all were rescheduled and subsequently undertaken at a later date.

This figure demonstrates an overall increase in the number of walkabouts undertaken by the Trust. However, 2013/14 saw a fall in the number carried out by the Trust’s executive directors. This is due to changes taking place within the executive team, which then impacted on the availability of substantive directors to undertake the walkabouts.

In general, the rounds have been very useful as a learning opportunity. In particular board members and governors felt they got a real feel for front-line service delivery and that helped to triangulate what is read in board papers in relation to the experience of patients and staff.

Staff reported that communication had improved over the last year, with areas of excellent practice identified such as the 18-week communication cell run by the surgical business unit and a “you said, we did” board on one of the wards.

Care rounds were seen in operation and particular attention was paid to the checks implemented in relation to turning a patient and the reduction of pressure ulcers. One staff nurse had developed a simple flow chart to inform staff of what to do if a patient was deemed at risk following a Waterlow assessment. If this proves successful it will be assessed before rolling out across all the wards.

How we reported and monitored our progress throughout the year
The feedback from the walk rounds is reported to the quality assurance committee three times a year as part of the quality account. The quality assurance committee look for where there are themes that are identified during the ward walk, as well as actions that are taken following them.
Clinical effectiveness priorities 2013/14

Identification of patients with dementia

Why did we choose this priority?
This priority was 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.

What we set out to do
We set out to baseline how many patients over the age of 75 are assessed for signs of dementia on admission.

All of the work to implement this remains ongoing. There are plans for a PAS alert so that patients with dementia can be identified on the PAS system to ensure appropriate care is put in place. This was unable to move forward until the new Medway PAS was functional; the coding for this is due to be agreed through the Trust-recognised channels for agreeing new codes in May 2014. The nurse specialists and secretaries have collated a list of memory clinic patients diagnosed with dementia, in preparation for this.

How did we measure our improvement and what were our targets?
We set a target of 90%* and measurement through the audits below.

How we reported and monitored our progress throughout the year
The feedback from this priority is reported to the quality assurance committee quarterly as part of the quarterly quality report update.

2013/14 performance
The Trust has set a target of 90% for patients to be assessed for dementia within 72 hours. In 2013/14 we have performed at an average for the year of 91.9%. The chart below shows the monthly performance against the 90% target since data collection for this priority began in September 2012.

For the number of patients with positive assessment for dementia referred for further advice/follow up, the Trust has set a target of 90%. In 2013/14 we have performed at an average for the year of 99%. The chart below shows the monthly performance against the 90% target since data collection for this priority began in September 2012.

*As a result of the work done by the external auditors during the audit, it has been recognised that this data has been incorrectly measured and this has been addressed going forward.
Appropriate training for staff in the care of patients with dementia

Why did we choose this priority?
The Trust recognised through comments from staff on the inpatient survey that to improve the patient experience we needed to improve the way we manage patients with dementia, and in order to achieve this appropriate training for staff needed to be in place.

What we set out to do
We have implemented an on-going dementia awareness training programme. It is a two-hour awareness session for all staff except medics and student nurses. Additionally, individual requests from specific areas for departmental training are responded to by the dementia nurse specialists.

The Trust has also introduced a system of link staff, whereby the trained staff member can cascade training regarding cognitive assessment, instruct their departmental staff to do these assessments and provide refresher tutorials.

How did we measure our improvement and what were our targets?
We undertook a baseline assessment to identify the staff, wards and departments requiring appropriate training. This enabled the Trust to agree a training plan.

How we reported and monitored our progress throughout the year
A report detailing progress is submitted to our quality assurance committee, three times a year.

2013/14 performance
This was a new priority for the Trust this year and so there is no information on previous years. The training figures for the reporting period 2013/14 show that 77 members of staff have received core training in dementia awareness.

In addition, 30 staff in the radiography department were trained by the dementia clinical nurse specialist outside the core training.

October 2013 saw 49 dementia champions trained across Trust business units.

The day assessment unit and link staff are regularly given refresher training on cognitive assessment.

62-day target for cancer waits

Why did we choose this priority?
This priority relates to an 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 received 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.

What we set out to do
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.
How did we measure our improvement and what were our targets?
The Trust has a target set an interim internal target of 85% of patients to begin treatment within 62 days of referral. This is a stepping stone for the Trust, as we recognise the need to meet the national target and implement works to achieve this.

How we reported and monitored our progress throughout the year
Performance throughout the year has been monitored via the monthly integrated performance report to the board.

2012/1013 performance

2013/1014 performance

Four hour accident and emergency target
Why did we choose 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 in being treated in a timely manner and therefore chose to incorporate this into our quality indicators for the coming year.

What we set out to do
We began 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 undertaken place includes:

- Reviewing our staffing rotas to bring them in line with our levels of activity
- Development of the emergency nurse practitioner (ENP) 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 did we measure our improvement and what were our targets?
The A&E department have measured our improvement against the national target of 95% of all A&E attendances to be either admitted or treated and discharged within four hours on a weekly basis.

We recognised that we have had problems with achieving this target so welcomed the urgent and emergency care Intensive Support Team into the Trust to undertake a review of our emergency care.

They were pleased to see good progress across a large number of areas since their previous visit and particularly pleased to observe a significant and sustained improvement in clinical leadership both in the ED and in acute medicine.

However they recognised that we continued to have challenges in the robustness of some new pathways and, as a result, performance against the four-hour standard on a week-by-week basis is still fragile despite the good work undertaken to date.

How we reported and monitored our progress throughout the year
Performance throughout the year has been monitored via the monthly integrated performance report to Trust board.

2013/14 performance

In March 2014 the NHS Quality Surveillance Group (QSG) recommended that Southend University Hospital NHS Foundation Trust should be called to a quality risk summit, which was held on the 31st March 2014. A network of QSGs has been established across the country to bring together different sectors of health and care economies to share information and intelligence to protect the quality of care patients receive.

Following the summit, a system-wide action plan has been developed with all external partners, including regulators and commissioners, in agreement and all will be held to account for the delivery of the action plan.

Patient experience priorities 2013/14

Supporting carers of people with dementia

Why did we choose 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.

What we set out to do
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 audits 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 did we measure our improvement and what were our targets?
Bi-monthly audits comprising questions asked of carers have been carried out by the Trust’s dementia team.

How we reported and monitored our progress throughout the year
Results from the bi-monthly audits have been reported through the board’s quality assurance committee.
2013/14 Performance
Completion of audit by carer/next of kin (by quarter)

Pain relief

Why did we choose 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 complaint responses and also patient surveys where the Trust has consistently scored around mid-range.

What we set out to do
Listen to our patients, understand their needs and learn from their experiences. Our main aim will be to provide appropriate pain relief in a timely and professional manner to reduce suffering.

How did we measure our improvement and what were our targets?
A patient satisfaction audit was collated and presented to the quality assurance committee. A new audit is being prepared for July 2014 to evaluate the work that has been in place since the audit was undertaken.

Based on the audit results that were broken down to individual wards, the acute pain team has targeted training in poor performing areas.

How we reported and monitored our progress throughout the year
As part of the area for improvement identified from the audit, the Trust has implemented the single nurse check of Oramorph in areas that have achieved compliance with their pharmacy audit. This enables the nurse to dispense the important pain relief on their own without waiting for another qualified nurse to be available.

A month-long trial was initially undertaken and the results audited and presented to the professional nursing and midwifery forum (PNMF) and director of pharmacy.

Development of patient focus groups

Why did we choose this priority?
We wanted to increase the engagement in each of the Trust’s business units to develop patient focus groups which deal specifically with the issues that patients of that business unit might face.

What we set out to do
Each of the business units needs to assess whether a brand new group needs to be established, or whether a group could be built on a less-used existing group. The groups will provide the forum for members to discuss difficulties that affect them directly, through which it is hoped that an in-depth understanding of patient issues will be developed and appreciated.

How did we measure our improvement and what were our targets?
Our target was to have a focus group set up in each business unit feeding into a central Trust-wide focus group by the end of the year.

How we reported and monitored our progress throughout the year
Through the year we have had some difficulty recruiting to the focus groups. However at year end we now have groups in four of the business units, with the first Trust-wide group meeting in May 2014.
It showed that during the trial on Castle Point ward 71.5% of patients waited 10-15 minutes for Oramorph and 28.5% waited longer than 30 minutes.

At the end of the trial, 89% of patients had waited 5-10 minutes and 11% 10-15 minutes, nobody had waited more than 15 minutes. At the end of the trial, 100% of patients were satisfied with the pain relief given to them.

On Hockley ward during the trial, 71.5% waited 10-15 minutes for Oramorph, 28.5% more than 30 minutes. At the end of the trial, 75% waited 5-10 minutes for Oramorph, 25% waited 10-15 minutes, nobody waited longer than 15 minutes. Again there was a 100% satisfaction rate with the pain relief given to the patient.

Once the ‘single nurse Oramorph’ process has been ratified it will be rolled out to all ward areas.

Further work will include working with our colleagues in the chronic pain service, dementia team and learning disability services to introduce the ‘Abbey pain scoring’ system for patients who are not able to communicate their pain.
Part Two: 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 2013/14, 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 41 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 96.9 per cent of the total income generated from the provision of relevant health services by the Southend University Hospital NHS Foundation Trust for 2013/4.

Information on participation in national clinical audits and national confidential enquiries:

During 2013/14, 46 national clinical audits and four national confidential enquiries were relevant to the services provided to people by Southend University Hospital NHS Foundation Trust. Of these studies, the Trust aimed to participate in 36 (78%) of national clinical audits and four (100%) national confidential enquiries for which it was eligible. Actual participation figures for 2013/14, however, were 31 (67%) national clinical audits and four (100%) national confidential enquiries.

These are listed below alongside the number of cases submitted for each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Where the Trust intended to participate but did not, the reason is listed against the relevant audit.

<table>
<thead>
<tr>
<th>National Clinic Audit</th>
<th>Category</th>
<th>Applicable to SUHFT</th>
<th>SUHFT participation</th>
<th>Participation in terms of % required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult critical care (case mix programme – ICNARC CMP)</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>100% all critical care admissions</td>
</tr>
<tr>
<td>Severe asthma (Royal College of Emergency Medicine)</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>(50 patients) Data collection submitted on 14 April 2014</td>
</tr>
<tr>
<td>Paracetamol overdose (Royal College of Emergency Medicine)</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>(50 patients) Data collection submitted on 14 April 2014</td>
</tr>
<tr>
<td>Sepsis (Royal College of Emergency Medicine)</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>(50 patients) Data collection submission on 14 April 2014</td>
</tr>
<tr>
<td>Severe trauma (Trauma Audit &amp; Research Network (TARN))</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>94% of all patients that fit criteria; ongoing data submission</td>
</tr>
<tr>
<td>National joint registry (NJR)</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>National Hip Fracture Database</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Emergency laparotomy</td>
<td>Acute</td>
<td>Yes</td>
<td>Yes</td>
<td>Data collection underway</td>
</tr>
<tr>
<td>Potential donor audit (NHS &amp; Transplant)</td>
<td>Blood and Transplant</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>National Clinic 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>National Comparative Audit of Blood transfusion</td>
<td>Blood and Transplant</td>
<td>Yes</td>
<td>Yes</td>
<td>Anti-D study 100% (46 patients)</td>
</tr>
<tr>
<td>Anti-D</td>
<td></td>
<td></td>
<td></td>
<td>Data submission due by April 30th 100% (24 patients)</td>
</tr>
<tr>
<td>Information &amp; Consent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td>Blood and Transplant</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Lung Cancer (NCLA)</td>
<td>Cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of our expected patients</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all eligible patients on-going data submission</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>Cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients on-going data submission</td>
</tr>
<tr>
<td>Head and Neck oncology (DAHNO)</td>
<td>Cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all eligible patients</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Cancer</td>
<td>Yes</td>
<td>No</td>
<td>Did not participate (Resource issues)</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCCA)</td>
<td>Heart</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients</td>
</tr>
<tr>
<td>Acute Coronary syndrome of Acute myocardial infarction (MINAP)</td>
<td>Heart</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients on-going data submission</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Heart</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients on-going data submission</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>Heart</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all patients on-going data submission</td>
</tr>
<tr>
<td>Peripheral vascular surgery (VSGBI Vascular Surgery Database, NVD)</td>
<td>Heart</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of all eligible patients on-going data submission</td>
</tr>
<tr>
<td>Diabetes (Adult), includes National Diabetes Inpatient Audit (NADIA)</td>
<td>Long term conditions</td>
<td>Yes</td>
<td>Yes</td>
<td>100% (91) of all patients on day of audit</td>
</tr>
<tr>
<td>Inflammatory Bowel disease (IBD)</td>
<td>Long term conditions</td>
<td>Yes</td>
<td>No</td>
<td>Did not participate (awaiting appointment to lead posts)</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>Long term conditions</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of eligible patients</td>
</tr>
<tr>
<td>Renal Transplantation (NHSBT UK Transplant Registry)</td>
<td>Long term conditions</td>
<td>Yes</td>
<td>Yes</td>
<td>100% of eligible patients</td>
</tr>
<tr>
<td>National Clinic 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>COPD</td>
<td>Long term conditions</td>
<td>Yes</td>
<td>Yes</td>
<td>Data collection 1st Feb – 31st May 2014</td>
</tr>
<tr>
<td>Rheumatoid and early Inflammatory Arthritis</td>
<td>Long term conditions</td>
<td>Yes</td>
<td>Yes</td>
<td>Data collection not started to date</td>
</tr>
<tr>
<td>National Dementia Audit (NAD)</td>
<td>Older people</td>
<td>Yes</td>
<td>No</td>
<td>Did not participate (awaiting appointment to lead posts)</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SNNAP)</td>
<td>Older people</td>
<td>Yes</td>
<td>Yes</td>
<td>100% eligible patients</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme</td>
<td>Older people</td>
<td>Yes</td>
<td>Yes</td>
<td>Pilot audit started in February 2014</td>
</tr>
<tr>
<td>Maternal Infant and Perinatal (MBRACE-UK)</td>
<td>Women’s &amp; Children’s Health</td>
<td>Yes</td>
<td>Yes</td>
<td>100% on-going data collection</td>
</tr>
<tr>
<td>Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>Women’s &amp; Children’s Health</td>
<td>Yes</td>
<td>No</td>
<td>Did not participate (resource issues)</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Women’s &amp; Children’s Health</td>
<td>Yes</td>
<td>Yes</td>
<td>100% on-going data collection</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Women’s &amp; Children’s Health</td>
<td>Yes</td>
<td>Yes</td>
<td>100% (120) of all eligible patients</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>Other</td>
<td>Yes</td>
<td>Yes</td>
<td>Data submitted per quarter</td>
</tr>
<tr>
<td>National audit of Seizure Management (NASH)</td>
<td>Other</td>
<td>Yes</td>
<td>No</td>
<td>Did not participate (Application made outside of deadline.)</td>
</tr>
</tbody>
</table>
The national confidential enquiries that Southend University Hospital NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

<table>
<thead>
<tr>
<th>NCEPOD</th>
<th>Applicable to SUHT</th>
<th>SUHT participation</th>
<th>Participation in terms of % required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower limb amputation</td>
<td>Yes</td>
<td>Yes</td>
<td>7 cases submitted to date (this study is still open)</td>
</tr>
<tr>
<td>Subarachnoid haemorrhage</td>
<td>Yes</td>
<td>Yes</td>
<td>2 cases submitted</td>
</tr>
<tr>
<td>Alcohol related liver</td>
<td>Yes</td>
<td>Yes</td>
<td>3 cases included 100%</td>
</tr>
<tr>
<td>Tracheostomy care</td>
<td>Yes</td>
<td>Yes</td>
<td>8 cases included</td>
</tr>
</tbody>
</table>

The reports of two national clinical audits were reviewed by the provider in 2013/14 and Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

**Myocardial Ischemia National Audit project (MINAP) for the National Institute for Cardiovascular Outcomes Research (NICOR)**

The MINAP is a national clinical audit of the management of heart attack. As part of this audit, we submitted data for 451 admissions to NICOR for the audit.

The outcomes showed that the trust had 99.9% data compliance overall and 100% compliance for all required data, except the recording of the patient’s glucose levels, which was 98%. Where applicable, all patients had been prescribed with secondary prevention medications.

To improve the quality of health care we undertook the following actions: We conducted our own audit of the recording of glucose levels and found that in some cases these were being recorded as a negative or a positive rather than showing the actual figure. Training was provided to staff to reinforce the need to change practice and record the actual glucose level.

**National Oesophago-Gastric Cancer Audit**

The National Oesophago-Gastric Cancer Audit covered the quality of care given to patients with oesophago-gastric (OG) cancer. The audit evaluated the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.

The outcome of the audit was that the Trust was meeting six of the eight recommendations of care. The exceptions were in respect of the use of a national standardised nutritional screening tool and the recording of the proportion of emergency hospital admissions and the development of strategies for reducing emergency admissions of patients with OG cancer.

To improve the quality of health care we undertook the following actions: We adapted a locally-validated nutritional screening tool, which takes into account a patient’s underlying medical condition(s) that may contribute to malnourishment. In respect of emergency admissions, we implemented increased acute oncology ward rounds to better identify those patients admitted as an emergency. The Trust is also developing a local strategy with key stakeholders to better monitor and prevent emergency admissions.
Local clinical audits:

The reports of three local clinical audits were reviewed by the provider in 2013/14 and Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit of the completion of the Barthel Index for all patients on admission and discharge to the Stroke Unit at Southend Hospital:

The Barthel Index consists of ten areas that measure a stroke patient’s daily functions, specifically the activities of daily living and mobility. These include feeding, moving from wheelchair to bed and return, grooming, transferring to and from a toilet, bathing, walking on level surface, going up and down stairs, dressing, and continence of bowels and bladder.

This was a re-audit that sampled 910 patients using Southend Hospital’s stroke services and demonstrated that improvements had been made in all ten categories set out under the Barthel Index since the previous year’s audit. In comparison to the previous audit, the completion on admission of the Barthel Index had increased by 9% (to 90%) and on discharge by 3% (to 85%).

To improve the quality of health care we undertook the following actions: We conducted awareness sessions for rehabilitation staff to reinforce the requirement that the Barthel Index must be completed for our stroke patients upon their admission. This topic will be re-audited in 2014/15.

Audit of Nevro High Frequency Spinal Cord Stimulation (SCS):

The Trust uses conventional SCS but trialled a new method of high-frequency stimulation. The audit was conducted to compare the outcomes of both methods using the Nevro device in 26 patients.

The results of the audit showed that high-frequency SCS gave significantly better back pain relief than the conventional method. Patients experienced pain relief without paraesthesia and were able to drive with the high-frequency system switched on. Conventional stimulation predominantly helps with neuropathic limb pain but high-frequency SCS helped both back and limb areas. The Nevro device can be used on both high-frequency and conventional settings. This allowed for reduced theatre time per procedure. The trial success rate for high-frequency SCS was 90% versus 70-75% for conventional stimulation.

To improve the quality of health care we undertook the following actions: We provided staff with training on the use of the Nevro high-frequency device.
Audit of Cardiac Services  
– Implantable Loop Recorders:

An implantable loop recorder (ILR) is a small device, implanted under local anaesthesia, which has the capacity to monitor and record heart rhythms. The audit was conducted to assess the service following the development of a physiologist-led implantation procedure in 2013. The Trust was among the first wave of hospitals in the UK to develop a cardiac physiologist-led implantation service.

Based on population, current NICE, European and American guidelines recommend that at least 42 ILR’s should be implanted at Southend University Hospital per year. However, the actual figures showed that the Trust carried out far fewer than the recommended procedures. The audit also showed that a cardiac physiologist is able to independently perform an ILR implant procedure with a consultant cardiologist being on site in case any issues require escalation. At the time of the audit, consultant cardiologist intervention had not been required in any cases.

To improve the quality of health care we undertook the following actions: We will continue with the physiologist-led service as it allows for better continuity of patient care, easier access to the service and the reduction of waiting times. We are designing a protocol for loop recorder implantation in younger patients, which will increase the implant rate and improve patient outcomes.

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 2013/14 who were recruited during that period to participate in research approved by a research ethics committee was 928.

Information on the use of the CQUIN framework:

A proportion of Southend University Hospital NHS Foundation Trust’s income in 2013/14 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 2013/14 and for the following 12-month period are available electronically on the Monitor website.

The amount of income received by Southend University Hospital NHS Foundation Trust in 2013/14 that was conditional upon achieving quality improvement and innovation goals was £1,203,200. This is the figure up to and including Quarter 3 payments. Quarter 4 income, at the time of production of this report, is still being finalised. However, the value total for CQUIN income for 2013/14 stands at £2,001,604. (£1,902,861 in 2012/13).
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 Trust currently has no conditions on its registration.

The Care Quality Commission has not taken enforcement action against Southend University Hospital NHS Foundation Trust during 2013/4.

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

Care Quality Commission (CQC) visits

The CQC visited the Trust in May 2013 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.

Areas visited included accident and emergency, theatres, outpatients, x-ray and the maternity unit. The Trust was found to be non-compliant with six of eight outcomes assessed. A subsequent action plan was devised and implemented to remedy the areas of poor practice identified.

A second inspection was undertaken by the CQC in October 2013 to assess whether the Trust had been successful in addressing concerns identified during the first inspection. The CQC found the Trust to be compliant with all six outcomes assessed.

<table>
<thead>
<tr>
<th>Outcomes inspected</th>
<th>Routine inspection: May 2013</th>
<th>Routine inspection revisit: October 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Respecting and involving people who use services</td>
<td>Moderate action</td>
<td>Compliant</td>
</tr>
<tr>
<td>4: Care and welfare of people who use services</td>
<td>Moderate action</td>
<td>Compliant</td>
</tr>
<tr>
<td>5: Meeting nutritional needs</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td>6: Cooperating with other providers</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td>10: Safety and suitability of premises</td>
<td>Minor Action</td>
<td>Compliant</td>
</tr>
<tr>
<td>13: Staffing</td>
<td>Moderate action</td>
<td>Compliant</td>
</tr>
<tr>
<td>14: Supporting workers</td>
<td>Moderate action</td>
<td>Compliant</td>
</tr>
<tr>
<td>16: Assessing and monitoring the quality of service provision</td>
<td>Moderate action</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
Information – Data Quality

Information on the quality of data:

Southend University Hospital NHS Foundation Trust submitted records during 2013/14 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% (February 2014) for admitted patient care (99.8% in 2012/13)
  - 99.9% (February 2014) for outpatient care (99.9% in 2012/13)
  - 99.0% (February 2014) for accident and emergency care (99.2% in 2012/13).

- which included the patient’s valid General Medical Practice Code was:
  - 100% (February 2014) for admitted patient care (100% in 2012/13)
  - 100% (February 2014) for outpatient care (100% in 2012/13)
  - 100% (February 2014) for accident and emergency care (100% in 2012/13).

NB: At the time of production the Health and Social Care Information Centre (HSCIC) had yet to publish Secondary Use Services (SUS) data quality statistics for March 2014.

Southend University Hospital NHS Foundation Trust’s Information Governance Assessment Report overall score for 2013/14 was 80% and was graded satisfactory.

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 4.5 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.
Part Two: 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>Measurement of SHMI</td>
</tr>
<tr>
<td>(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.</td>
</tr>
<tr>
<td>Reporting of National PROMS</td>
</tr>
<tr>
<td>(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>Readmission rates</td>
</tr>
<tr>
<td>Percentage of patients aged— (i) 0 to 15; and (ii) 16 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>The trust’s responsiveness to the personal needs of its patients during the reporting period.</td>
</tr>
<tr>
<td>Staff Friends and Family test</td>
</tr>
<tr>
<td>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>Patient Friends and Family test</td>
</tr>
<tr>
<td>The data made available and covering services for inpatients and patients discharged from A&amp;E (types 1 and 2). (Gateway reference 00931)</td>
</tr>
<tr>
<td>VTE</td>
</tr>
<tr>
<td>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>Clostridium difficile cases</td>
</tr>
<tr>
<td>The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.</td>
</tr>
<tr>
<td>Patient safety incidents</td>
</tr>
<tr>
<td>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:

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Nat Value</th>
<th>Nat Avg</th>
<th>Banding</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>1.0205</td>
<td>1.000</td>
<td>Within Expected</td>
<td>74/142</td>
<td>1.1697 (BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST)</td>
<td>0.6523 (THE WHITTINGTON HOSPITAL NHS TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>1.0161</td>
<td>1.000</td>
<td>Within Expected</td>
<td>69/142</td>
<td>1.2475 (BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST)</td>
<td>0.7102 (THE WHITTINGTON HOSPITAL NHS TRUST)</td>
</tr>
</tbody>
</table>

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

- At the time of publication, these were the latest national reporting figures available
- 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 so the quality of its services:

- Mortality review group – this group’s vision is to undertake a review of all unexpected deaths to establish learning for improvements in the future.
### Reporting of PROMS: Groin Hernia

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Nat Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2013</td>
<td>30/09/2013</td>
<td>0.104</td>
<td>0.085</td>
<td>17/78</td>
<td>0.019 (THE DUDLEY GROUP NHS FOUNDATION TRUST)</td>
<td>0.138 (DERBY HOSPITALS NHS FOUNDATION TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>0.057</td>
<td>0.080</td>
<td>118/132</td>
<td>0.021 (MID YORKSHIRE HOSPITALS NHS TRUST)</td>
<td>0.119 (ASHFORD AND ST PETER’S HOSPITALS NHS FOUNDATION TRUST)</td>
</tr>
</tbody>
</table>

### Reporting of PROMS: Hip Replacement Primary

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Nat Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2013</td>
<td>30/09/2013</td>
<td>-</td>
<td>0.441</td>
<td>-</td>
<td>0.373 (HINCHINGBROOKE HEALTH CARE NHS TRUST)</td>
<td>0.492 (SOUTH TEES HOSPITALS NHS FOUNDATION TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>0.418</td>
<td>0.429</td>
<td>91/136</td>
<td>0.319 (THE WHITTINGTON HOSPITAL NHS TRUST)</td>
<td>0.538 (LEWISHAM AND GREENWICH NHS TRUST)</td>
</tr>
</tbody>
</table>

### Reporting of PROMS: Knee Replacement Primary

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Nat Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/04/2013</td>
<td>30/09/2013</td>
<td>-</td>
<td>0.339</td>
<td>-</td>
<td>0.264 (BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST)</td>
<td>0.429 (WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>0.254</td>
<td>0.312</td>
<td>132/136</td>
<td>0.195 (WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST)</td>
<td>0.376 (ISLE OF WIGHT NHS TRUST)</td>
</tr>
</tbody>
</table>

32
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

PROMS are collated quarterly, and due to the information captured, the surveys run two quarters behind. This has meant that groin hernia data is only available for the first half of the 2013/14 financial year. In addition to this, nationally, no data is available for 2013/14 for hip replacement, knee replacement or varicose veins. At the time of publication, these were the latest national reporting figures available.

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

- 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.
- 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 continue the enhanced recovery programme during the next year.
Reporting of Re-admissions:

This indicator shows emergency re-admissions within 28 days of discharge from hospital.

### Reporting of Re-admissions: 0-15 years

<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></td>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>6.59</td>
<td>10.04</td>
<td>4/48</td>
<td>13.58 (NORTH CHESHIRE HOSPITALS NHS TRUST)</td>
<td>5.10 (THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST)</td>
</tr>
</tbody>
</table>

### Reporting of Re-admissions: 16+

<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></td>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>11.06</td>
<td>11.26</td>
<td>25/51</td>
<td>13.50 (VARIOUS TRUSTS)</td>
<td>8.96 (WINCHESTER AND EASTLEIGH HEALTHCARE NHS TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2010</td>
<td>31/03/2011</td>
<td>11.17</td>
<td>11.17</td>
<td>27/50</td>
<td>13.00 (THE LEWISHAM HOSPITAL NHS TRUST)</td>
<td>7.68 (NEWHAM UNIVERSITY HOSPITAL NHS TRUST)</td>
</tr>
</tbody>
</table>
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

A review of readmissions has been completed by clinicians from both the primary care setting and the Trust.

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

- Further 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, and this will continue in 2014/15
- 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
- The two targets (elective / non elective) added to the integrated performance report in 2012/13, remain and if attained, put the Trust in the top 25th percentile of our peers (other university hospitals)
- Targets were set with an interim goal of 9.5% and an ultimate goal of 3.25% of all discharges for re-admissions following an admission
- Further focus has been and will continue to be applied to ensure the Trust understands and manages readmissions appropriately
- Performance throughout the year will be monitored via the monthly integrated performance report to the board.

The Trust’s responsiveness to the personal needs of its patients 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></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>68.4</td>
<td>68.1</td>
<td>62/156</td>
<td>57.4 (CROYDON HEALTH SERVICES NHS TRUST)</td>
<td>84.4 (THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST)</td>
</tr>
<tr>
<td></td>
<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>85.0 (QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST)</td>
</tr>
</tbody>
</table>
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

We have actively surveying patients following their discharge in relation to the national Friends and Family test. We have set a target to survey at least 15% of patients in A&E and as inpatients by the end of March 2014. At the end of 2013/14 we have exceeded this target in both areas. All comments received via the Friends and Family surveys are shared with the relevant teams and feedback is requested. At the time of publication, these were the latest national reporting figures available.

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

• Beginning the implementation of the Friends and Family test within the maternity department in October 2013, ahead of national introduction. We have also introduced new technologies such as text messaging, which is proving successful in increasing responses from A&E patients. This is to be introduced within maternity in the coming year.

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>2013 survey</td>
<td>67.0</td>
<td>68</td>
<td>87/163</td>
<td>(40) Mid Yorkshire hospitals NHS Trust and North Cumbria University Hospital NHS Trust</td>
<td>(94) Queen Victoria Hospital NHS Foundation Trust</td>
</tr>
<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>
</tbody>
</table>

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

The results of the 2013 NHS staff survey were reported to the Trust board on 26 March 2014. The Trust has decided to conduct further engagement with staff to determine the underlying reasons for this data so that informed decisions can be made in order to achieve an improvement. At the time of publication, these were the latest national reporting figures available.

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

• The Trust will engage with its staff to determine the underlying reasons for this data so that informed decisions can be made to achieve an improvement. It will do this by holding staff focus groups with an external specialist facilitator. Arising from the focus groups an action plan will be developed. The Trust will also work with its ‘Have Your Say’ staff focus group to develop actions and to monitor progress towards achievement of the action plan.
• The Trust began consultation and engagement with its trades unions and professional associations regarding the survey results and development of actions to achieve improvement in March 2014.
### Measurement of VTE

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Avg Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2013</td>
<td>31/12/2013</td>
<td>86.3%</td>
<td>95.8%</td>
<td>160/162</td>
<td>77.7% (NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST)</td>
<td>100% (Various trusts)</td>
<td></td>
</tr>
<tr>
<td>01/07/2013</td>
<td>30/09/2013</td>
<td>94.6%</td>
<td>95.7%</td>
<td>135/165</td>
<td>81.7% (WESTON AREA HEALTH NHS TRUST)</td>
<td>100% (Various trusts)</td>
<td></td>
</tr>
</tbody>
</table>

At the time of publication, these were the latest national reporting figures available.

### VTE Return – Data Submissions

<table>
<thead>
<tr>
<th>Month</th>
<th>Original % Compliance</th>
<th>Date of Submission</th>
<th>Number of Risk Assessments</th>
<th>Number of Admissions</th>
<th>Refresh % Compliance</th>
<th>Date of Refresh Submission</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-13</td>
<td>95.55%</td>
<td>30/04/2013</td>
<td>5726</td>
<td>5977</td>
<td>95.80%</td>
<td>10/06/2013</td>
<td>95%</td>
</tr>
<tr>
<td>May-13</td>
<td>95.51%</td>
<td>28/06/2013</td>
<td>6002</td>
<td>6276</td>
<td>95.63%</td>
<td>15/07/2013</td>
<td>95%</td>
</tr>
<tr>
<td>Jun-13</td>
<td>95.10%</td>
<td>29/07/2013</td>
<td>5877</td>
<td>6168</td>
<td>95.28%</td>
<td>09/08/2013</td>
<td>95%</td>
</tr>
<tr>
<td>Jul-13</td>
<td>94.86%</td>
<td>27/08/2013</td>
<td>6633</td>
<td>6978</td>
<td>95.06%</td>
<td>10/08/2013</td>
<td>95%</td>
</tr>
<tr>
<td>Aug-13</td>
<td>93.85%</td>
<td>30/09/2013</td>
<td>5920</td>
<td>6297</td>
<td>94.01%</td>
<td>14/10/2013</td>
<td>95%</td>
</tr>
<tr>
<td>Sep-13</td>
<td>94.35%</td>
<td>28/10/2013</td>
<td>6044</td>
<td>6375</td>
<td>94.81%</td>
<td>12/11/2013</td>
<td>95%</td>
</tr>
<tr>
<td>Oct-13</td>
<td>94.26%</td>
<td>28/11/2013</td>
<td>6212</td>
<td>6586</td>
<td>94.32%</td>
<td>17/12/2013</td>
<td>95%</td>
</tr>
<tr>
<td>Nov-13</td>
<td>91.03%</td>
<td>27/12/2013</td>
<td>5807</td>
<td>6320</td>
<td>91.88%</td>
<td>13/01/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Dec-13</td>
<td>70.80%</td>
<td>28/01/2014</td>
<td>4208</td>
<td>5902</td>
<td>71.30%</td>
<td>18/02/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Jan-14</td>
<td>92.66%</td>
<td>28/02/2014</td>
<td>5908</td>
<td>6293</td>
<td>93.88%</td>
<td>17/03/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Feb-14</td>
<td>95.01%</td>
<td>26/03/2014</td>
<td>5613</td>
<td>5908</td>
<td>N/A*</td>
<td>N/A*</td>
<td>95%</td>
</tr>
</tbody>
</table>

*National processes for VTE data returns do not allow for refresh of data submissions in February.*
Southend University Hospital NHS Foundation Trust considers that this data 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.

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

- Wards raising awareness with staff, auditing and closely monitoring compliance so that any practice issues can be identified and addressed. Training has been out in place to improve performance; this has included running a VTE study day and introducing an e-learning package
- Reviewing data transfer processes to ensure data is correctly recorded and reported; including implementing an escalation process for those staff entering VTE data to PAS to be able to raise issues with named staff who can assist them
- Carrying out spot audits of all patients. The results reported to wards, matrons, BUDs/ABUDs to inform additional actions required to improve performance
- Providing a prompt, recorded confirmation of assessment and intervention, with alerts which flag delays or non-compliance and running “live” compliance reports.

### Measurement of C difficile cases:

<table>
<thead>
<tr>
<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>01/04/2012</td>
<td>31/03/2013</td>
<td>13.4</td>
<td>17.3</td>
<td>51/161</td>
<td>30.8 (North Tees &amp; Hartlepool)</td>
<td>0.0 (Several trusts)</td>
</tr>
<tr>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>15.6</td>
<td>22.2</td>
<td>47/161</td>
<td>58.2 (The Dudley Group of Hospitals)</td>
<td>0.0 (Several trusts)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-Diff in Qtr.</td>
<td>7</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>OBD for Qtr.</td>
<td>46,378</td>
<td>45,240</td>
<td>44,606</td>
</tr>
<tr>
<td>Ratio Per 100,000 OBD</td>
<td>15.09</td>
<td>11.05</td>
<td>17.93</td>
</tr>
</tbody>
</table>
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

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

NB: At the time of production of this account the number of C. difficile infection cases for Quarter 4 is 11; however, this is unable to be reported against ratio per 100,000 bed days as national data is not yet published for occupied bed days.

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

- Adhering to strict antibiotic stewardship – antibiotic ward rounds
- Double testing for suspected C. diff infections. GDH (Glutamate Dehydrogenase). This identifies C. diff carriers. These patients are isolated if having loose stools – with full infection prevention measures in place
- All staff to have infection prevention and control training/update in relation to C. diff. This is ward-based and staff are provided with a training booklet as evidence
- A robust root cause analysis process following every case. MDT for all cases. All lessons learned are shared and acted on
- CCG review each case and a decision is made as to whether the case is avoidable or unavoidable
- The use of Tristel trigger spray (chlorine based product) for the cleaning of all commodes and toilet areas
- C. diff summit meeting was held March 2014. Dr March Reacher epidemiologist from Cambridge, CCG and Public Health found no reason for the increased rate identified.
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

This data shows a positive reporting culture in the Trust with an increase in reporting overall and a decrease in incidents causing harm. The NRLS (National Reporting and Learning System) which is the patient safety function of the NHS Commissioning Board considers that organisations with a high level of reporting low/near-miss incidents and a low level of incidents causing harm is indicative of a positive reporting culture. We encourage the reporting of all incidents and feedback about changes in practice implemented locally which may be usefully shared more widely to improve the quality of care and safety. Sharing lessons learned from the analysis of incidents is vital to ensuring improvements and reducing risk of similar occurrences.

Due to the changes in reporting processes and responsibilities of national public bodies such as the Health and Social Care Information Centre (HSCIC), no national benchmarking data was available at the time of producing this account.

<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>13-14</td>
<td>6543 (32.43 by 1000 bed days)</td>
<td>29</td>
<td>0.4%</td>
</tr>
<tr>
<td>12-13</td>
<td>5968 (31.02 by 1000 bed days)</td>
<td>36</td>
<td>0.6%</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:

- Improving the electronic and paper incident forms to make them easier to use and therefore make the reporting process less daunting for staff
- Promoting the use of the governance helpline to enable staff to raise queries regarding incidents and enable anonymous reporting of incidents
- Distributing a weekly incident round up to staff to feed back on recent incidents and lessons learned
- Governance team attending business unit governance meetings to provide advice and guidance on the incident processes
- Simplifying the investigation paperwork to enable staff to complete root cause analysis of incidents in a timely fashion.
Part Three: Other information
An overview of the quality of care, based on performance in 2013/14

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 2012/13 Quality Account, and continued to do so for 2013/14.

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

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

How we reported and monitored our progress throughout the year:

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>1</td>
<td>0</td>
<td>1</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>3</td>
<td>3</td>
</tr>
<tr>
<td>2013/2014</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Each month the total number of cases of Clostridium difficile infection (C. diff) is 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>
<tr>
<td>2013/2014</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>31</td>
</tr>
</tbody>
</table>

All data shown in the above tables is collated in-house by our own infection control and prevention team, is governed by standard national definitions and shows a count of instances of C.diff, rather than the rate per 1000 bed days (see page 38).
Nutrition assessment on admission

Why was this priority chosen?
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 therefore chose to continue to focus on this in recognition of the impact nutrition has on how patients feel and respond to treatment.

What did we do to improve?
We 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 expanded our snack round pilot project to more areas and continued to promote the work of our volunteer Feeding Buddies.

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

A monthly clinical audit is undertaken by the matrons and includes aspects of on-going assessment of nutritional risk, monitoring and referral to a dietician if required. Ward teams are then able to identify areas that can be improved further.

How we reported and monitored our progress throughout the year
The target for compliance with the nutritional assessment is 90% and this is reported monthly to the Trust board and at the professional nursing and midwifery forum.

The chart below illustrates overall average compliance for the Trust with undertaking a nutritional assessment.

Nutritional Assessment Performance 2012/13

Nutritional Assessment Performance 2013/14
Director safety walkabout implementation and outcome

Why did we choose this priority?
We have chosen to continue the work introduced on this measure from last year.

Patient safety walkabout rounds are a way of ensuring that the corporate team are informed first hand, regarding the safety concerns of frontline staff. They are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised. Walk rounds can be instrumental in developing an open culture where the safety of patients is seen as the priority of the organisation.

What we set out to do
We will see an increased compliance with our key targets outlined earlier, in particular actions identified 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 sought to extend the walkabout team to include members of our Council of Governors, further promoting a culture of openness and transparency.

How did we measure our improvement and what were our targets?
During 2013/14 a total of 196 walkabouts took place by executive directors, non-executive directors and governors – accompanied by a matron from the relevant business unit.

Twenty were postponed for various reasons, the Trust being under additional pressures, (meetings that took priority and staff sickness), but all were rescheduled and subsequently undertaken at a later date.

This figure demonstrates an overall increase in the number of walkabouts undertaken by the Trust. However, 2013-14 saw a fall in the number carried out by the Trust’s executive directors. This is due to changes taking place within the executive team, which then impacted on the availability of substantive directors to undertake the walkabouts.

In general, the rounds have been very useful as a learning opportunity. In particular board members and governors felt they got a real feel for front-line service delivery and that helped to triangulate what is read in board papers in relation to the experience of patients and staff.

Staff reported that communication had improved over the last year, with areas of excellent practice identified such as the 18-week communication cell run by the surgical business unit and a “you said, we did” board on one of the wards.

Care rounds were seen in operation and particular attention was paid to the checks implemented in relation to turning a patient and the reduction of pressure ulcers. One staff nurse had developed a simple flow chart to inform staff what to do if a patient was deemed at risk following a Waterlow assessment. If this proves successful it will be assessed before rolling out across all the wards.

How we reported and monitored our progress throughout the year
The feedback from the walk rounds is reported to the quality assurance committee quarterly as part of the quarterly quality account update. The quality assurance committee look for where there are themes that are identified during the ward walk as well as actions that are taken following them.
2) Domains of quality: Clinical effectiveness
62-day target for cancer waits

Why was this priority chosen?
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 where they receive 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.

What did we do to improve?
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 therefore continued to work closely with our colleagues to ensure these referrals were made in a timely way to minimise the delay to patients.

How we reported and monitored our progress throughout the year
Performance throughout the year has been monitored via the monthly integrated performance report to the board.

The table below shows the Trust’s performance against 62-day cancer waits over the last financial year.

<table>
<thead>
<tr>
<th>Cancer 62 day waits for first treatment comprising either:</th>
<th>Threshold</th>
<th>2013/14 Q1</th>
<th>2013/14 Q2</th>
<th>2013/14 Q3</th>
<th>2013/14 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>From urgent GP referral</td>
<td>&gt;85%</td>
<td>83.1%</td>
<td>85.6%</td>
<td>85.8%</td>
<td>81.3%</td>
</tr>
<tr>
<td>From consultant led screening service referral</td>
<td>&gt;90%</td>
<td>92.9%</td>
<td>100.0%</td>
<td>95.9%</td>
<td>90.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threshold</th>
<th>2012/13 Q1</th>
<th>2012/13 Q2</th>
<th>2012/13 Q3</th>
<th>2012/13 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>From urgent GP referral</td>
<td>&gt;85%</td>
<td>83.1%</td>
<td>84.9%</td>
<td>88.6%</td>
</tr>
<tr>
<td>From consultant led screening service referral</td>
<td>&gt;90%</td>
<td>92.6%</td>
<td>100.0%</td>
<td>95.4%</td>
</tr>
</tbody>
</table>
The chart below specifically shows our performance throughout the 2013/14 year for Southend patients only, and against our internal 85% target (re urgent referral).

**Readmission rates**

**Why was this priority chosen?**
Southend University Hospital used this indicator as a measurement of quality in its 2012/13 Quality Account, and continued to do so for 2013/14.

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. It measures emergency re-admissions within 28 days of discharge from hospital.

**What did we do to improve?**
- A review of readmissions has been completed by clinicians from both the primary care setting and the Trust
- Further 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, and this will continue in 2014/15
- Weekly report which looks at patients who have been readmitted and are currently in the hospital goes to the discharge team to see if readmission could have been avoided and investigates the reasons for readmission
- The two targets (elective / non elective) added to the integrated performance report in 2012/13, remain and if attained, put the Trust in the top 25th percentile of our peers (other university hospitals)
- Targets were set with an interim goal of 9.5% and an ultimate goal of 3.25% of all discharges for re-admissions following an admission
- Further focus has been and will continue to be applied to ensure the Trust understands and manages readmissions appropriately.
- Performance throughout the year will be monitored via the monthly integrated performance report to the board.
Summary hospital-level mortality indicator (SHMI)

Why was this priority chosen?
This is a quality indicator that all trusts are required to report in their quality accounts and was recorded as at 1.0322 for the period October 2012 – September 2013.

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.

Mortality review group has been set up and this group’s vision is to undertake a review of all unexpected deaths to establish learning for improvements in the future.

3) Domains of quality: 
Patient experience
Embedding quality at Southend University Hospital

Quality strategy

Our vision is ‘Excellent care from excellent people’ and this is underpinned by our values: Everybody Matters, Everything Counts, Everyone’s Responsible.

We don’t see our vision just as a slogan but regard it as the guiding principle at the heart of everything we do.

The Quality Strategy was first introduced in 2012. In order to develop our quality objectives we have consulted with patients and the public, our staff and our partners. We analysed what we do well and highlighted areas where there is room for improvement.

We continually review our current performance against a range of standards and these are incorporated and reported in our annual quality account. For the forthcoming year we have agreed specific goals as a Trust board ensuring that this quality strategy reflects the overall strategic direction of the Trust and the needs of the communities that we serve.

For the revised 2014 plan, we have specifically incorporated the learning from the Francis Report and the Keogh Review and will build on the improvements that have already been achieved.
What are our strategic objectives?
SUHFT board of directors identified the organisation’s top three quality priorities and these are further underpinned by the ambitions identified by the Keogh Report. The strategic objectives are summarised as:

**Leadership for quality**
- Providing quality data for the boards and business units (ambition 2)
- Engagement in working with our academic networks (ambition 5).

**Improving the patient experience**
- Providing a positive patient experience (ambition 3)
- Ensuring that our patients and staff have confidence in the quality assessment by the Care Quality Commission (ambition 4)
- Enabling staff to undertake responsible information sharing (ambition 2).

**Improving clinical outcomes and avoiding harm**
- Reducing avoidable deaths (ambition 1)
- Ensuring nursing and skill mix is safe and appropriate to caseload (ambition 6)
- Engagement with junior doctors as the clinical leaders of tomorrow (ambition 7)
- Engagement with staff to provide the best outcomes for our patients (ambition 8).

**Patient stories**
Last year saw the introduction of patient’s stories at Trust board.

The stories provide details of what has gone well or not so well during their admission.

They also give 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.

**Hospital Heroes and staff achievement awards**
Each month the board recognises a member of staff who has gone above and beyond in their role to help deliver excellent patient care.

In September 2013 we held our first annual staff achievement awards. Winners of the monthly Hospital Heroes award were joined by staff who had best demonstrated the Trust’s values ‘Everybody Matters, Everything Counts, Everyone’s Responsible’.

**Serious Incidents and never events**
During the course of 2013/14 there has been one never event 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 92% 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.

A summary of any serious incidents are reported to the clinical assurance committee and Trust board with the quality assurance committee ensuring that all actions are implemented from the learning from serious incidents.

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

**Nursing Levels**
During 2013/14 an overview of the nursing levels on each of our wards has been undertaken and presented to the Trust board. It was recognised that there was some investment required to increase the nursing levels in some wards and clinical areas. It was agreed at the Trust board that this investment would be undertaken and we are currently undertaking a recruitment plan to have 120 more nurses join the Trust.
Mortality review group

During the past 12 months, the Trust has recognised that we need to get better at understanding how we interpret and act on our published mortality figures. In order to do this we have set up a hospital mortality group that is chaired by the medical director with engagement from both clinicians and nursing staff.

Friends and Family Test

In the last year, the Trust has been actively surveying patients following their discharge in relation to the Friends and Family test. Our current target is to survey at least 15% of patients both in A&E and inpatients. At the end of this year we have exceeded this target in both areas. With effect from 1st April 2014, the inpatient target increases to a minimum of 20% and we can report that we are already exceeding this target.

In October 2013, we began the roll out of the test within the maternity department, ahead of the national introduction. Whilst we have only seen a slow start in this area, new technologies such as text messaging, which has already been successful in the A&E department, is to be introduced in the coming year. It is hoped that increasing the coverage of text messaging will improve the Trust’s net promoter score further.

All comments received via the Friends and Family test are shared with the relevant teams and feedback is requested. Moving forward, all comments will be collated in the same way as comment cards to allow for more detailed analysis.
Performance against 2013/14 key national priorities

The Trust continues to review the services that it provides, 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 table below sets out the performance of the Trust against the key national priorities from Monitor’s Risk Assessment Framework.

The Trust has struggled to deliver and sustain acceptable levels of performance against the key operational standards, namely RTT 18-week admitted performance, the A&E 95% waiting times target and the 62-day cancer referral to treatment target.

Monitor Risk Assessment Framework 2013-14
Targets and Indicators with thresholds

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Threshold</th>
<th>Weighting</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted</td>
<td>90%</td>
<td>1</td>
<td>88.5</td>
<td>87.7</td>
<td>89</td>
<td>88.1</td>
</tr>
<tr>
<td>Access</td>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate - non-admitted</td>
<td>95%</td>
<td>1</td>
<td>97.4</td>
<td>95.7</td>
<td>95.5</td>
<td>96.2</td>
</tr>
<tr>
<td>Access</td>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway</td>
<td>92%</td>
<td>1</td>
<td>95</td>
<td>94.4</td>
<td>93.8</td>
<td>93.4</td>
</tr>
<tr>
<td></td>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>95%</td>
<td>1</td>
<td>91</td>
<td>96.5</td>
<td>94.2</td>
<td>87.9</td>
</tr>
<tr>
<td></td>
<td>All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer</td>
<td>85%</td>
<td>1</td>
<td>83.1</td>
<td>85.6</td>
<td>85.8</td>
<td>81.3</td>
</tr>
<tr>
<td>Area</td>
<td>Indicator</td>
<td>Threshold</td>
<td>Weighting</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
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<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Access</td>
<td>All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral</td>
<td>90%</td>
<td>1</td>
<td>92.9</td>
<td>100</td>
<td>95.9</td>
<td>90.9</td>
</tr>
<tr>
<td>Access</td>
<td>All cancers: 31-day wait for second or subsequent treatment comprising surgery</td>
<td>94%</td>
<td>1</td>
<td>93.1</td>
<td>94.5</td>
<td>98.5</td>
<td>97.2</td>
</tr>
<tr>
<td>Access</td>
<td>All cancers: 31-day wait for second or subsequent treatments comprising anti-cancer drug treatments</td>
<td>98%</td>
<td>1</td>
<td>98.9</td>
<td>100</td>
<td>99.1</td>
<td>99.7</td>
</tr>
<tr>
<td>Access</td>
<td>All cancers: 31-day wait for second or subsequent treatment comprising radiotherapy</td>
<td>94%</td>
<td>1</td>
<td>98.7</td>
<td>98.3</td>
<td>97</td>
<td>99.3</td>
</tr>
<tr>
<td>Access</td>
<td>All cancers: 31-day wait from diagnosis to first treatment</td>
<td>96%</td>
<td>1</td>
<td>95.6</td>
<td>98.3</td>
<td>99.2</td>
<td>98.5</td>
</tr>
<tr>
<td>Access</td>
<td>Cancer: 2 week wait from referral to date first seen comprising all urgent referrals (cancer suspected)</td>
<td>93%</td>
<td>1</td>
<td>95.3</td>
<td>95.6</td>
<td>95.3</td>
<td>94.2</td>
</tr>
<tr>
<td>Access</td>
<td>Cancer: 2 week wait from referral to date first seen comprising for symptomatic breast patients (cancer not initially suspected)</td>
<td>93%</td>
<td>1</td>
<td>94.2</td>
<td>96.1</td>
<td>97.4</td>
<td>89.3</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Clostridium (C.) difficile - meeting the C. difficile objective</td>
<td>de minimis</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Certification against compliance with requirements regarding access to health care for people with learning disability</td>
<td>N/A</td>
<td>1</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
Maintained by Methods Insight Analytics

Acute Trust Quality Dashboard

The Acute Trust Quality Dashboard provides an assessment of quality across the 5 domains of the NHS Outcomes Framework:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protect them from avoidable harm

A sixth domain has been created “Organisational Context” which contains a number of metrics which look at organisational behaviour and measures useful in interpreting other metrics in the Dashboard.

Report Overview

Section title listing NHS outcome framework domain.

Indicator reference

Actual value for this indicator

The mean value for all acute trusts in England

SPC Chart displaying variance for each indicator

If a trust is in this range their rate is worse than expected by chance (2SD or 95%)*

If a trust is in this range their rate is better than expected by chance (2SD or 95%)*

This diamond represents the value for the acute trust.

The vertical bar represents the average value for all acute Trusts in England

If a trust is in this range their rate is much better than expected by chance (99.8% or 3SD)**

The scale of each chart is dynamic to show a range that enables each measure to be viewed clearly for the trust in question. See Meta data document for further information.

* For a full description of each metric and metadata, please see technical guidance.

** These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.8%) control limits. Values within these limits (the light grey section) are said to display ‘normal cause variation’ in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display ‘special cause variation’ at a two standard deviation level, and a cause other then random chance should be considered. Values outside these sections (in the dark green or red sections) also display ‘special cause variation’ but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.

For enquiries please contact: insightanalytics@methods.co.uk
## Acute Trust Quality Dashboard

### 1. Preventing People from Dying Prematurely

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Value</th>
<th>National Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD02 Age / Sex-standardized hospital mortality from conditions amenable to healthcare</td>
<td>Q1 2014</td>
<td>85.8</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD03 Age / Sex-standardized hospital mortality to neurosurgical risk</td>
<td>Q1 2014</td>
<td>91.9</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD14 Hospital mortality per 1,000 births (excluding still births)</td>
<td>Q1 2014</td>
<td>4.89</td>
<td>6.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD15 Summary Hospital Mortality Indicator (SHMI)</td>
<td>Q4 2013</td>
<td>102.1</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD16 Emergency (pending data)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD20 Mortality (sub-group 86)</td>
<td>Q4 2012</td>
<td>93.3</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD23 Sepsis (sub-group 76)</td>
<td>Q4 2012</td>
<td>85.9</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD24 SMIS (sub-group 76)</td>
<td>Q4 2012</td>
<td>95.2</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD25 SMIS (sub-group 76)</td>
<td>Q4 2012</td>
<td>83.8</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD29 SMIS (sub-group 76)</td>
<td>Q4 2012</td>
<td>99.9</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD40 SMIS (sub-group 85)</td>
<td>Q4 2012</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD41 SMIS (sub-group 86)</td>
<td>Q4 2012</td>
<td>88.3</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD43 SMIS (sub-group 86)</td>
<td>Q4 2012</td>
<td>88.3</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD47 SMIS (sub-group 86)</td>
<td>Q4 2012</td>
<td>93.3</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD50 % of patients with a fractured neck of femur operated on within 48 hours</td>
<td>Q1 2014</td>
<td>50.0%</td>
<td>74.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD51 Mean wait - % waiting less than 27 days from decision to treat to first treatment</td>
<td>Q1 2014</td>
<td>95.4%</td>
<td>98.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD52 Cancer wait - % waiting less than 62 days from GP referral to treatment</td>
<td>Q4 2013</td>
<td>83.3%</td>
<td>82.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. Enhancing Quality of Life for People with Long Term Conditions

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Value</th>
<th>National Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ01 % emergency admissions for &gt;65 years old with dementia</td>
<td>Q1 2014</td>
<td>15.3%</td>
<td>14.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EQ03 LOS (Days) for patients &gt;65 years old admitted in an emergency with Dementia</td>
<td>Q1 2014</td>
<td>6.5</td>
<td>14.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EQ04 LOS (Days) for patients &gt;65 years old admitted in an emergency</td>
<td>Q1 2014</td>
<td>8.1</td>
<td>10.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EQ05 % of admissions for long stay LOS for emergency antenatal care conditions</td>
<td>Q1 2014</td>
<td>41.1%</td>
<td>41.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Helping People to Recover from Episodes of Ill Health or Following Injury

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Value</th>
<th>National Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR01 Emergency readmission - % within 30 days following non-elective admission</td>
<td>Q1 2014</td>
<td>14.0%</td>
<td>14.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR02 Emergency readmission - % within 30 days following elective admission</td>
<td>Q1 2014</td>
<td>1.0%</td>
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<tr>
<td>HR03 Emergency readmission - % within 2 days following elective admission</td>
<td>Q1 2014</td>
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<tr>
<td>HR04 Emergency readmission - % within 2 days following non-elective admission</td>
<td>Q1 2014</td>
<td>0.8%</td>
<td>0.9%</td>
<td></td>
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<tr>
<td>HR05 Emergency readmission - % within 30 days following non-elective admission (Same Specialty)</td>
<td>Q1 2014</td>
<td>5.2%</td>
<td>6.0%</td>
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<tr>
<td>HR06 Emergency readmission - % within 30 days following elective admission (Same Specialty)</td>
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<td>3.1%</td>
<td>2.8%</td>
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<tr>
<td>HR07 Emergency readmission - % within 2 days following non-elective admission (Same Specialty)</td>
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<td>1.1%</td>
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<tr>
<td>HR08 Emergency readmission - % within 2 days following elective admission (Same Specialty)</td>
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<td>0.4%</td>
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<tr>
<td>HR09 Emergency readmission - % within 10 days following discharge - Angina</td>
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<td>17.3%</td>
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<tr>
<td>HR10 Emergency readmission - % within 30 days following discharge - Angina</td>
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<td>5.9</td>
<td>3.9</td>
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<tr>
<td>HR11 Emergency readmission - % within 30 days following discharge - Asthma</td>
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<td>6.0%</td>
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<tr>
<td>HR12 Mean length of stay (LOS) for patients admitted for Angina</td>
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<td>5.9</td>
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<td>HR15 Mean length of stay (LOS) for patients admitted for Asthma</td>
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<td>9.7</td>
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<td>HR16 Mean length of stay (LOS) for patients admitted for COPD</td>
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### Clinical Effectiveness

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<tr>
<td>H121 % of eligible patients taking part in PROs eligible FCHs (Age Jan 12)</td>
<td>Q1 2014</td>
<td>33.9%</td>
<td>36.1%</td>
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<tr>
<td>H123 Patient Reported Outcome Measures - % Patients reporting an improvement following attending (1 Jan 2012)</td>
<td>Q1 2014</td>
<td>86.6%</td>
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<td>H125 Patient Reported Outcome Measures - % Patients reporting an improvement following attending (1 Jan 2012)</td>
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<td>H127 Patient Reported Outcome Measures - % Patients reporting an improvement following attending (1 Jan 2012)</td>
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<td>83.3%</td>
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<td>H129 Patient Reported Outcome Measures - % Patients reporting an improvement following attending (1 Jan 2012)</td>
<td>Q1 2014</td>
<td>35.9%</td>
<td>51.0%</td>
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[Source: Southend University Hospital NHS Foundation Trust]
## Acute Trust Quality Dashboard

### Patient Experience

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<td>PE01</td>
<td>Aug 13</td>
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<td>21.7</td>
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<td>PE02</td>
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### Patient Safety

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### Organisational Context

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For enquiries, please contact: insightanalytics@methods.co.uk

For page numbering, please contact: methods@methods.co.uk
Acute Trust Quality Dashboard

This section of the dashboard is included to allow hospitals to provide notes on the content of the dashboard and indicators where required.

There are no notes for this trust.

For enquiries please contact: insightanalytics@methods.co.uk
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 (voluntary) from local Healthwatch
- Comments (voluntary) from governors’ patient and carer experience group
- Statement of directors’ responsibilities in respect of the quality account
- Independent Auditor’s Report to the Council of Governors of Southend University Hospital NHS Foundation Trust on the quality account.
Other information – Annexes

NHS Southend CCG commentary on Southend University Hospitals NHS Foundation Trust 2013/14

NHS Southend Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the Quality Account prepared by Southend University Hospitals NHS Foundation Trust (the Trust) as the co-ordinating 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.

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

However, it is noted that there is some absence of data relating to:

- Patient safety incidents that resulted in ‘death’
- SHMI data relating to palliative care diagnosis
- Readmission rates by age is provided as 0-15 years and 16 years plus which is in variance to the prescribed information.

The Trust has had a challenging year with key areas of concern relating to performance which has an impact on the quality of services, patient safety and patient experience.

The standard for patients to be seen within four hours in Accident and Emergency has caused concern and this has been highlighted in the report, noting the requirement of a Quality Risk Summit to be held to review the Trust’s position. The Trust has acknowledged that the ability to meet this standard remains challenging and there is an action plan in place which is closely monitored through the Urgent Care Working Group.

The 18 week waiting times from referral to treatment has not been met for all specialties consistently and this remained a focus throughout the year with remedial plans required.

The Trust has noted that one of the quality priorities for 2013/2014 was to meet the standard for patients with cancer to be 62 day wait to treatment following a GP referral. This standard has proved to be difficult to achieve both in SUHFT and across other local Trusts. Performance against the standard has been monitored throughout the year; again work is in progress to implement the agreed actions to achieve the target.

One of the national Key Performance Indicators (KPIs) for 2013/2014 was to ensure that 95% of patients who were admitted to hospital were risk-assessed for venous thromboembolism. The Trust have shown in the Quality Account that following a positive start to the reporting year there was a drop in the percentage of achievement and therefore a potential impact on the quality and safety of the service. The actions outlined will be monitored through the regular meetings held by the CCG with the Trust to review the quality and safety of service delivery and to prevent patient harm.
On the review of the priorities set for 2013/2014 the Trust has confirmed its commitment to ensuring that patients with dementia were identified early to ensure a more positive outcome to care and treatment. The target was set for 90% and again this target was met during the earlier part of the reporting year but has not been achieved for the latter part of the year. A comprehensive action plan to recover this position has been developed and the implementation will be closely monitored.

Considering the above NHS Southend CCG fully supports the strong priorities for patient safety and clinical effectiveness that the Trust has set for 2014/15 and recognises the additional patient quality initiatives such as managing pain and nutritional needs that the Trust is implementing. The CCG also welcomes the work on nurse staffing skill mix and the increased Board walkabouts.

NHS Southend CCG was assured that following the CQC re-visit in October the six outcomes previously assessed as moderate/minor in May 2013 were judged to be met.

The CCG is aware that the Trust had no reported cases of MRSA bacteraemia during 2013/14 but the level of CDiff infection was higher than the target that had been set by NHS England. Each of these infections underwent a thorough review by the Trust and the CCG to identify any factors that need to be addressed to avoid reoccurrence.

Outcomes from Friends and Family testing demonstrate that in-patient scores have been maintained at or above national average and the Trust has recognised that additional initiatives are required to enhance the response rate for both A&E and maternity touch points.

The Trust has reported on their processes for reporting and investigating serious Incidents and Never Events. The CCG has worked collaboratively with the Trust to improve the reporting and investigation of these incidents. Each incident is reviewed to ensure continuous improvement in patient safety. The Trust has noted that there was one Never Event during the year which was reported and monitored through the required system.

NHS Southend CCG continues to meet regularly with the Trust to seek assurance on performance, delivery of care and to ensure that quality, patient safety and experience remain paramount. Assurances on the quality of service provision will continue to be monitored through a programme of agreed reporting timescales, monitoring of agreed action plans and quality visits to strengthen assurance processes to observe in real time the delivery of patient care.

Linda Dowse
Chief Nurse
29 May 2014
Feedback from Healthwatch Southend

We would like to thank Southend University Hospital NHS Foundation Trust for inviting us to comment on its quality account 2013/14.

We have been impressed with the openness and willingness to engage with us of individual trust staff, with whom we have worked on a number of issues such as learning disabilities, patient experience and safeguarding. For example, we were pleased to be invited to sit on the trust’s learning disabilities committee, and attend regularly.

Trust staff have attended and contributed to our events on dementia, Asperger syndrome and child and adolescent mental health services. These staff have displayed professionalism, caring attitudes, and commitment to person centred provision that are a credit to the trust.

We have also had the opportunity to work with David Fairweather, membership manager, who has been very helpful to us in promoting our messages and supporting the patient experience agenda, and with whom we have been in discussion around sharing resources in engaging the Polish and Roma communities.

With regard to citizen feedback, what we have received about the trust is:

- 50% positive
- 36% negative
- 14% mixed, neutral or unclear.

(Total of 170 comments received. This does not include formal health complaints for which we have provided advocacy support.)

We will share the raw data with the trust on request.

Our comments on the quality account are as follows:

Part 1 Statement on quality from the chief executive

- We are delighted to have seen the trust’s performance against the 4-hour A&E target improve so dramatically in recent months, and offer our congratulations to everyone involved in achieving this success. We do feel however that, here and later in the account (clinical effectiveness priorities 2012/15), attributing the previous poor performance to “…The number of patients using our emergency services increasing year on year…” is contrary to evidence supplied by NHS Southend CCG that “Attendances have been quite constant, with a drop in quarter 3; bed occupancy is well below the national average; and delayed transfers of care are low.”

- Our understanding is that difficulties meeting the 4-hour A&E target stemmed from a lack of A&E consultants and suitably senior clinical decision making staff, with the physical size of the department being a further factor, and we were surprised to see no mention of these factors in the account

- We hope that planning to cope with the kind of winter pressures seen in previous years (but not 2013/14) is timely and effective, so that the A&E department can avoid any failure to meet the target this coming winter

- Ambulance transfer delays are still amongst the worst in the region, according to the latest figures we have from EEAST. We hope these figures improve soon and mirror the improvements made against the 4-hour waiting target

- Public comments received by Healthwatch Southend relating specifically to the A&E department are 56% negative, 40% positive and 4% mixed, neutral or unclear. (This does not include formal complaints on which we have provided advocacy.) We hope to see an improvement in such comments over the coming year.
Patient safety priorities 2013/14

- We commend the trust for its improvements in patient safety, and especially for implementing walkabouts for directors and governors. The importance of senior decision makers being familiar with the real issues on the ground cannot be overstated.
- We question the development of “…a simple flowchart to inform staff of what to do if a patient was deemed at risk following a Waterlow assessment.” Coal face innovation is clearly positive, but surely there is national guidance, for example, SSKIN bundles that give the necessary guidance as well as being approved by NICE and other national and regulatory NHS bodies. We would hope such guidance is already deeply embedded in the trust’s clinical practice.

Clinical effectiveness priorities 2013/14

- We commend the trust on what appears to be some very positive advances in dealing with issues around dementia. Our recent event on dementia, and the ‘dementia friends’ training undertaken by our staff and volunteers, showed us that this kind of proactive identification and provision of reasonable adjustments can extend a person’s independence and improve quality of life.

Executive safety walkabouts implementation and outcome

- Reducing the average length of stay from 10-14 days to 3-5 days would appear to be a major achievement for the trust. We hope this does not impact negatively on the safety of discharges. Healthwatch England are undertaking a special inquiry into unsafe discharges in the country’s hospitals, and we at Healthwatch Southend will be involved in this.

62 day target for cancer waits

- We share the trust’s concerns over its performance against the 62 day target for cancer waits, and hope it can dramatically improve in this area over the coming year.

Patient stories

- We commend the trust on presenting patient stories at its board meetings, and thereby enabling an understanding of people’s issues at all levels.

Jonathan Keay
Healthwatch manager
22 May 2014

Care Quality Commission (CQC) visits

- We commend the trust on the improvements made following the CQC report in May and the subsequent ‘all clear’ inspection in October.
Feedback from Southend-on-Sea Borough Council

Southend-on-Sea Borough Council
Department for Corporate Services
John Williams - Head of Legal & Democratic Services

Our ref:  
Your ref: fa  
Date: 19th May 2014  
Contact Name: F Abbott  
Telephone: 01702 215104  
Fax:  
E-mail: fionaabbott@southend.gov.uk  

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

Dear Ms Totterdell,

Quality Account 2013/14

Thank you for sending the draft Hospital Quality Account 2013/14.

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

"In view of the timescales for submitting comments on the Quality Account for 2013/14, we wish to advise you that the People Scrutiny Committee will not be submitting a formal 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.

We would very much like to thank you for the presentation you gave to members in December 2013 on the CQC inspection, A&E performance and maternity services. The Director of Nursing gave a very helpful presentation to members in January 2014 on End of Life Care issues. We would like to thank you for these extremely helpful and detailed presentations.

We have also recently written to you with our concerns about the A&E performance and would like to thank you for your positive response."

Yours sincerely

Fiona Abbott
Principal Committee officer

Cc Councillor Alex Kaye, Chairman, People Scrutiny Committee; Councillor Mark Flewitt, Vice Chairman, People Scrutiny Committee

Investors in People Silver

Corporate Director for Corporate Services: Sally Holland
Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER
Customer Contact Centre: 01702 215000; www.southend.gov.uk

Southend on Sea Borough Council
Feedback from Governors’ patient carer experience group

Members of this governors’ group were able to review the quality account for 2013-2014 at their meeting on the 6th May.

We are encouraged that the Trust is engaging with patients, staff and public in a variety of ways, enabling them to comment on what is important to them as individuals, when setting the priorities for improvement in 2014-15. We are in favour of the choices made under the various headings, but would have liked to see more emphasis in the account on how they will be achieved.

We were pleased to see that by making improvements to quality the Trust was compliant in all six of the outcomes assessed by the Care Quality Commission on the return inspection in October 2013.

It is good to see the assessment of older patients for signs of dementia, staff training to improve the care of these patients and greater involvement of their carers.

We liked the work on speedier pain control, with single nurse prescribing after appropriate training. We welcome the plans to increase the number of nurses and the formation of the mortality review group.

The group is especially disappointed by the failure of certain key national priorities:

- The 18-week Referral to Treatment (RTT) target
- The number spending more than four-hours in A&E
- Cancer patients to receive their first treatment within 62-days of an urgent referral.

We would have liked to see the following included in the account:

- During the year governors have held listening exercises in ophthalmology, maternity and outpatients, speaking to patients about their experiences of the hospital to learn what has gone well and where the Trust should improve
- Similarly we talk and listen to members and the public at member meetings and at community events
- A section on the efforts to improve the experience of patients with learning disabilities when they come to the hospital.
- The work of volunteers who are much appreciated by staff and patients.

Elaine Blatchford
Chair of the patient and carer experience group.
6 May 2014
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 2013/14;
- 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 2013 to May 2014
  - Papers relating to quality reported to the board over the period April 2013 to May 2014
  - Feedback from the commissioners dated 29 May 2014
  - Feedback from governors dated 6 May 2014
  - Feedback from local Health watch organisations dated 19 May 2014
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30 April 2014
  - The national inpatient survey 8 April 2014
  - The national staff survey 25 February 2014
  - The head of internal audit’s annual opinion over the trust’s control environment dated 21 May 2014

- 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

[Signatures]

Alan Tobias OBE
Chairman
27 May 2014

Jacqueline Totterdell
Chief executive
27 May 2014
Independent Auditor’s Report to the Board of Governors of Southend University Hospital NHS Foundation Trust on 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 2014 (the ‘Quality Account’) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C. difficile; total number of cases in the year reported on page 125; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers reported on page 130.

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 in the 2013/14 Detailed Guidance for External Assurance on Quality Accounts issued by Monitor; 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 2013 to May 2014
- Papers relating to quality reported to the Board over the period April 2013 to May 2014
- Feedback from the Commissioners, dated 29/05/2014
- Feedback from local Healthwatch organisations, dated 19/05/2014
- Feedback from governors dated 06/05/2014
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 April 2013 to 31 March 2014
- The national patient survey 2013
- The national staff survey 2013
- Care Quality Commission Intelligence Monitoring Report (which replaces quality and risk profiles), dated October 2013
- The Head of Internal Audit’s annual opinion over the trust’s control environment, dated 21/05/2014; 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 2014, 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, except 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
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the quality report
- 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 affect 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 of these criteria, may change over time. It is important to read the quality report 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 2014:

- The quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The quality report is not consistent in all material respects with the sources specified in the 2013/14 Detailed Guidance for External Assurance on Quality Reports; and
- The indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Ernst and Young
Chartered Accountants
Luton
Date: 29 May 2014