Southend University Hospital NHS Foundation Trust

Quality Account 2014 - 2015
Quality account 2014/15

Independent auditor’s report to the council of governors of Southend University Hospital NHS Foundation Trust on the quality account

We have been engaged by the council 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 2015 (the ‘quality account’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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 keeping to 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 2014/15 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 2014 to 29 May 2015;
- Papers relating to quality reported to the board over the period April 2014 to 29 May 2015;
- Feedback from the Commissioners, dated 29/05/2015;
- Feedback from local Healthwatch organisations, dated 17/05/2015;
- Feedback from governors dated 19/05/2015;
- The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/05/2015;
- The national patient survey, dated 24/02/2015;
- The national staff survey, dated 29/05/2015;
- Care Quality Commission Intelligence Monitoring Report, dated 14/05/2015;
- The Head of Internal Audit’s annual opinion over the trust’s control environment, dated 19/05/2015; 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 2015, 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’), and the 2014/15 Detailed Guidance for External Assurance on Quality Accounts issued by Monitor. Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the quality account.
- Reading the documents.
- A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can 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 account in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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 2014/15 Detailed Guidance for External Assurance on Quality Accounts; and
- The indicators in the quality account subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Ernst and Young LLP
Chartered Accountants
Luton
Date 29 May 2015
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, Sue Hardy. An update is also provided on the priorities that were set by the trust for 2014/15, and details of the priorities set for the coming year.

In Part Two, we have provided details of our priorities for quality improvement that we intend to provide for 2015/16 and details of how we have progressed in 2014/15.

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.

Throughout all parts of this quality account, where information on performance in previous years is available this has been included. The most up to date national and local information has also been included throughout.

In previous years the trust has referred, throughout the quality account, to clinical areas as Business Units (BU). The current document refers to these and to clinical directorates (CD), as from January 2015 clinically-led directorates were introduced to replace the Business Units. These clinical directorates provide improved engagement with clinical staff and create an environment of continuous improvement to deliver high quality care to our patients.

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

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

Statement on quality from the chief executive

Welcome to our quality account 2014/15, 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 is increasing year on year; however, significant progress has been made. We had a very positive start to the year achieving the four-hour target for five consecutive months, narrowly missing quarter one with 94.14% but comfortably achieving quarter two with 96.25%. Despite winter pressures and not reaching the target in the last two quarters we have consistently been one of the best achieving trusts in Essex.

We recognise that the 62 day cancer standard continues to be a significant challenge, particularly in our urology service. We have invited in external assistance from the national intensive support team to help us utilise best practice from other hospitals, and have produced a robust action plan to address performance issues which will be monitored throughout the year by the trust board.

Our priorities for 2015/16, which we established last year following consultation with staff, governors and members of the public will continue to be:

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

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

Clinical Effectiveness
- Make sure nursing skill mix is safe and appropriate to caseload
- 62 day ceiling for cancer waits
- 4 hour accident and emergency target
Our current registration status with the CQC is unconditional and the Commission has not taken any enforcement action against the trust during 2014/15. The CQC visited the trust in August 2014 in response to the concerns of stakeholders and information of concern received by the CQC about the trust’s urgent and emergency care services. The trust was found to be non-compliant with three regulations. A subsequent action plan was devised and implemented to remedy the areas of poor practice which were identified.

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 while 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.

Sue Hardy
Chief executive
April 2015
Part Two

Priorities for Improvement 2015/16:

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.

In February 2014 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 make sure 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. This year we have taken the decision that as these priorities were so important to our staff, patients and public we would continue to measure the same priorities in order to see year-on-year improvements.

Progress made since the publication of the 2013/14 quality account is described in part 3, as the priorities for improvement have not changed for the coming year and the qualities for improvement have formed our quality of care indicators.

Patient Safety Priorities 2015/16

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

World Health Organisation (WHO) checklist

Why have we chosen this priority?
We want to continue to make sure 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 that 100% of applicable patients who have surgery through theatres 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 clinical directorate’s governance meeting then onward to the clinical assurance committee though their clinical directorate’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 have we 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 have undertaken a comprehensive review of the 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 our target is that we achieve 85% 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?
Duty of candour over the past year has become a statutory requirement; our aim is that in all cases where Duty of Candour is applicable we will achieve 100% compliance.

The duty of candour applies to all patient safety incidents graded moderate or above.

Within 10 working days, or sooner, after becoming aware that a notifiable safety incident has occurred, we are required to:

- Notify the relevant person that the incident has occurred and
- Provide reasonable support to the relevant person in relation to the incident

This notification given must be followed by a written notification given or sent to the relevant person (patient or relative if patient is deceased) containing:

- The information provided as above
- Details of any investigation that will be required
- Results of any further enquiries into the incident, and
- An apology

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 is that we undertake this in 100% of applicable cases.

How will we report and monitor our progress?
Our progress will be monitored through bi-monthly reports that are taken to the trust board. Any issues will be escalated to the medical director.
Patient Experience Priorities 2015/16

Patient feedback

Why we have chosen this priority?
This priority was chosen with the overarching aim to provide a positive patient experience.

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 beyond 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 we could 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 extra comments from the Friends and Family test and monitor the changes in practice through this committee.

How will we report and monitor our progress?
We will have in place throughout the trust “you said, we did” posters following our patient’s feedback which will be reported to the clinical assurance committee. Progress will also be monitored through the number of patients who would recommend the hospital to friends and family and this will be reported to the clinical assurance committee.

Patient focus groups

Why have we chosen this priority?
We want to make sure that future developments within the organisation have input from patients and public engagement by seeking the views of patients and the public through focus groups both trust wide and in each of the clinical directorates.

How will we improve?
We set out to have focus groups in place in each of the clinical directorates reporting into a trust -wide group. We know that this is an important mechanism to get feedback so have kept this as a priority for the forthcoming year.

How will we measure our improvement and what are our targets?
We will measure the number of focus groups that are in place and then we will set targets for the number of meetings per year and how the groups are reporting the voice of these groups to make sure that future developments incorporate their views.

How will we report and monitor our progress?
The trust forum will report to the clinical assurance committee (CAC) with outcomes and action plans.
**Education and development programmes for all levels of staff**

**Why have we chosen this priority?**
We know that staff who is engaged with the trust values will reflect these elements in their practice thus providing a better patient experience.

**How will we improve?**
We will continue to develop and implement education and development programmes for all levels of staff based on our values, and include customer experience training.

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

**How will we report and monitor our progress?**
Friends and 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 and the attendance rates at these sessions.

**Clinical effectiveness priorities 2015/16**

**Make sure nursing skill mix is safe and appropriate to caseload**

**Why have we 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 months, providing assurance about the impact on quality of care and patient experience.

The trust will display in each ward the approved staffing levels and actual staffing levels on a shift to shift basis. The staffing levels will be monitored by the matrons to make sure safe care is maintained. The staffing levels for each ward will be reported to the trust board, including key quality, safety and patient experience measures.

Where staffing levels are below optimum in the short term, a risk assessment will be undertaken and reported to the clinical director / associate 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?**
Our target is to make sure that there are the right numbers of staff with the right skills in order to provide safe care. Action plans will be put in place where staffing is below optimum. Staffing levels will be displayed in clinical areas and on the website. Staffing levels will continue to be monitored through the trust board. The monitoring of outcomes in relation to patient safety, quality and patient experience will enable us to identify the impact of staffing levels on patient care.
**How will we report and monitor our progress?**
Staffing levels and key outcomes in relation to patient safety, quality and patient experience are reported regularly at each meeting of the trust board.

**62-day target for cancer waits**

**Why have we 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 make sure these referrals were made in a timely way to minimise the delay to patients.

The trust also set its own internal target of seeing 85% of patients, who are directly referred to us rather than via a neighbouring trust within 62 days, to make sure compliance with the overall target.

**How will we measure our improvement and what are our targets?**
The trust has adopted the national target of 85% of patients to begin treatment within 62 days of referral.

**Four-hour accident and emergency target**

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

We also recognise the importance for our patients 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 continue to review 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 and we have an Emergency Care Improvement Plan – to make sure we have the right number and type of specialty bed available. We remain committed to our workforce plan particularly with continuing to increase and recruit substantive consultants. We will carry on towards the future model of emergency care in the form of Advanced Care Practitioners (ACPs). We now have our senior ACP in place within the Emergency Department (ED) team. The trust is now creating the pathway for our future ACPs. We are starting to see a consistent increase in daily attendances and we will continue to strive to develop ways to adapt and improve our ED pathways.

**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 will continue to be 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 regular integrated performance reports presented at each meeting of the trust board.
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 2014/15, Southend University Hospital NHS Foundation Trust provided and/or sub contracted 42 relevant health services.

Southend University Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 42 of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 96.12% of the total income generated from the provision of relevant health services by the Southend University Hospital NHS Foundation Trust for 2014/15.

Information on participation in clinical audits and national confidential enquiries:

During 2014/2015, 30 national clinical audits and four national confidential enquiries covered relevant health services that Southend University Hospital NHS Foundation Trust provides.

During that period Southend University Hospital NHS Foundation Trust participated in 65% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries (NCEPOD) that Southend University Hospital NHS Trust was eligible to participate in during 2014/2015 are as follows:

National Clinic Audit
- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- Adult Community Acquired Pneumonia
- Bowel cancer (NBOCAP)
- Cardiac Rhythm Management (CRM)
- Case Mix Programme (CMP)
- Child health clinical outcome review programme
- Congenital Heart Disease (Paediatric cardiac surgery) (CHD)
- Coronary Angioplasty/National Audit of PCI
- Diabetes (Adult)
- Diabetes (Paediatric) (NPDA)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- Inflammatory Bowel Disease (IBD) programme
- Lung cancer (NLCA)
- Major Trauma: The Trauma Audit & Research Network (TARN)
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
- National Cardiac Arrest Audit (NCAA)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
- National Comparative Audit of Blood Transfusion programme
- National Complicated Diverticulitis Audit (CAD)
- National Emergency Laparotomy Audit (NELA)
- National Joint Registry (NJR)
- National Prostate Cancer Audit
- National Vascular Registry
- Neonatal Intensive and Special Care (NNAP)
- Non-Invasive Ventilation - adults
- Oesophago-gastric cancer (NAOGC)
- Paediatric Intensive Care Audit Network (PICANet)
- Pleural Procedure
- Prescribing Observatory for Mental Health (POMH)
- Pulmonary Hypertension (Pulmonary Hypertension Audit)
- Rheumatoid and Early Inflammatory Arthritis
- Sentinel Stroke National Audit Programme (SSNAP) Organisational
- Sentinel Stroke National Audit Programme (SSNAP) Clinical
- UK Cystic Fibrosis Registry

NCEPOD

- Sepsis
- Gastro-intestinal haemorrhage
- Lower limb amputation
- Tracheostomy care

2.3 The national clinical audits and national confidential enquiries that Southend University Hospital NHS Foundation Trust participated in during 2014/2015 are as follows:

National Clinic Audit

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- Bowel cancer (NBOCAP)
- Cardiac Rhythm Management (CRM)
- Case Mix Programme (CMP)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- Lung cancer (NLCA)
- Major Trauma: The Trauma Audit & Research Network (TARN)
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
- National Cardiac Arrest Audit (NCAA)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
- National Comparative Audit of Blood Transfusion programme

- National Complicated Diverticulitis Audit (CAD)
- National Emergency Laparotomy Audit (NELA)
- National Joint Registry (NJR)
- National Prostate Cancer Audit
- National Vascular Registry
- Neonatal Intensive and Special Care (NNAP)
- Oesophago-gastric cancer (NAOGC)
- Rheumatoid and Early Inflammatory Arthritis
- Sentinel Stroke National Audit Programme (SSNAP) Organisational
- Sentinel Stroke National Audit Programme (SSNAP) Clinical

NCEPOD

- Sepsis
- Gastro-intestinal haemorrhage
- Lower limb amputation
- Tracheostomy care

2.4 The national clinical audits and national confidential enquiries that Southend University Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
<table>
<thead>
<tr>
<th>National Clinic Audit</th>
<th>Participation in terms of % required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>100%</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP)</td>
<td>Up to 30 sample patients during data collection</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>100%</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>92.5%</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>100%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>90%</td>
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<tr>
<td>National Joint Registry (NJR)</td>
<td>100%</td>
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<tr>
<td>National Prostate Cancer Audit</td>
<td>100%</td>
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<tr>
<td>National Vascular Registry</td>
<td>100%</td>
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<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>100%</td>
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<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>100%</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) Organisational</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) Clinical</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCEPOD</th>
<th>Participation in terms of % required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastro-intestinal haemorrhage</td>
<td>20% of questionnaires/case notes were returned</td>
</tr>
<tr>
<td>Lower limb amputation</td>
<td>14% of questionnaires/case notes were returned</td>
</tr>
<tr>
<td>Tracheostomy care</td>
<td>100% of questionnaires/case notes were returned</td>
</tr>
</tbody>
</table>
2.5, 2.6, the reports of two national clinical audits were reviewed by the provider in 2014/2015 and Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

**National Chronic Obstructive Pulmonary Disease (COPD) Audit**

The core aim of the audit was to drive improvements in the quality of care and services provided for COPD patients. This was done through gathering and linking data to map the patient journey, compare performance and practice, highlight variations in patient care and outcomes, and drive up standards of patient care. The programme supported the Department of Health’s (DH) aims to improve the quality of services for people with COPD.

The outcomes showed that the trust had low mortality rates, good rates of oxygen prescribing and high rates of referral for smoking cessation and pulmonary rehabilitation. However, it found that the trust could improve on review times, recording of escalation status and the number of patients managed on respiratory wards.

To improve the quality of health care, we have undertaken to develop a COPD pathway. This will make sure that patients presenting with COPD have a rapid assessment with appropriate investigations requested; appropriate management started promptly (including documentation of an escalation plan) and are transferred to the most appropriate ward.

**National Care of the Dying Audit**

The core aim of the audit was to sample the quality of care that dying people receive in hospital. The audit also covered the treatment and support received by relatives of the patient and their involvement in decision making; the organisation of care, including availability of palliative care services, numbers of staff, training, and responsibilities for care. It looked at the care of 6580 people across 149 hospitals.

The results showed that the trust had good provision for promoting patient privacy, dignity and respect up to, including and after the death of the patient. However, it was also found that improvements were required in: information provision, specialist support, staff training, protocols for prescribing medication and feedback processes.

To improve the quality of health care we are undertaking a number of changes in response to the findings of the audit and as part of our wider review of our end-of-life care process. These include an annual audit of end-of-life care and annual report; review of our mortuary services and refurbishment of the mortuary; the introduction of a multi-disciplinary care plan for the last days of life; extra training on end-of-life care, and the implementation of the Gold Standard Framework for all patients nearing the end of life.
Local clinical audits

The reports of three local clinical audits were reviewed by the provider in 2014/2015 and Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Hepatitis B Vaccination in HIV infected patients

This audit was conducted to determine if HIV patients attending our service are screened and vaccinated for Hepatitis B in line with British HIV Association (BHIVA) guidelines. The BHIVA guidelines recommend that all HIV positive patients should be routinely immunised against Hepatitis B and receive double-dose strength of vaccine.

To improve the quality of health care, we undertook the following actions: we are developing a vaccination proforma and sticker to improve screening and documentation; double-dose Hepatitis B vaccinations are being given as a course of three, or as a single booster; vaccinations continue to be administered even in ‘non-responders’ since the majority will develop antibodies after repeated courses. Patients are reminded of the importance of having their levels checked and boosters offered.

Blood transfusion in paediatrics

This was a retrospective audit that was conducted to review our practice of paediatric transfusion against the standards of Great Ormond Street Hospital. This covered indication of blood transfusion, the amount of blood transfusion given, consent, complications and actions to address these, and the quality of documentation.

The results showed good practice in cross-checking and reactions and that at least 60% of patients had a transfusion less than 24 hours from the transfusion threshold. Improvements were required in documentation, the request system and overall risk management.

To improve the quality of health care, we are undertaking the following actions: We have implemented an on-line system to request blood products where the introduction of blood component, volume and special requirements are indicated. A doctors/nurses transfusion checklist has been prepared and is going through the approval process. Staff now prescribe blood in ‘mls’ and not ‘units’.

Audit of the quality of medicines counselling to inpatients

The aim of the audit was to assess the quality of medicines counselling to inpatients on newly prescribed medicines and the trust’s adherence to NICE guidance and Royal Pharmaceutical Society professional standards.

We interviewed 40 patients about their newly started medicines and asked if they had been counselled on their medications before they had been started; whether or not they knew why they were taking the medication and how they should take it, and whether they knew any common side effects of the medicine and how to manage them. We found that we were not always adhering to established guidance and standards in every case.

To improve the quality of health care, we undertook the following actions: We established a dedicated pharmacy training session on counselling patients, which ran in December 2014; we also incorporated counselling into prescriber teaching sessions for Foundation Year 1 and 2 doctors and for nursing staff; we have undertaken to re-audit our adherence to these guidelines by August 2015.
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 2014/15 who were recruited during that period to participate in research approved by a research ethics committee was 1313.

Information on the use of the CQUIN framework:

A proportion of Southend University Hospital NHS Foundation Trust’s income in 2014/15 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 2014/15 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 2014/15 that was conditional upon achieving quality improvement and innovation goals was £1,283,971. The figure is 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 2014/15 is forecast to be £1,470,576. (£2,001,604 in 2013/14).

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.

5.1 The Care Quality Commission has not taken enforcement action against Southend University Hospital NHS Foundation Trust during 2014/5.

6 and 6.1 removed from the reporting legislation by the 2011 amendments.

7.1 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) visit

The CQC visited the trust in August 2014 in response to the concerns of stakeholders and information of concern received by the CQC about the trust’s urgent and emergency care services.

Commission inspectors toured the Emergency Department, checked records, observed how services were delivered and spoke to both patients and staff. The trust was found to be non-compliant with three regulations. A subsequent action plan was devised and implemented to remedy areas of poor practice identified.
<table>
<thead>
<tr>
<th>Regulation</th>
<th>Area of non-compliance</th>
<th>Actions we have taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td><strong>Cleanliness and infection control</strong> People who use services and others were not protected against the risks associated with infection because of inadequate maintenance of appropriate standards of cleanliness and hygiene within the A&amp;E department.</td>
<td>Newly-built paediatric emergency department opened in February 2015 Storage areas reviewed and improved New commodes bought Staff reminded of their responsibilities to maintain an uncluttered environment Weekly cleaning spot checks and monthly cleaning audits implemented</td>
</tr>
<tr>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td><strong>Management of medicines</strong> People who use services and others were not protected against the risks associated with the unsafe use and management of medicines because the medicines were not stored securely and were not always disposed of appropriately within the A&amp;E department.</td>
<td>Pharmacy link staff introduced in the acute medical unit Safe medicines management policies and procedures reviewed with staff Regular medicines spot checks introduced</td>
</tr>
<tr>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td><strong>Staffing</strong> There were an insufficient number of suitably qualified, skilled and experienced trained nurses and consultant doctors within the A&amp;E Department.</td>
<td>Twelve registered nurses recruited Two paediatric registered nurses recruited and the trust has in place a further recruitment campaign. Rolling advertisement in place to recruit permanent consultants in the A&amp;E department</td>
</tr>
</tbody>
</table>
Information on the quality of data:

Southend University Hospital NHS Foundation Trust submitted records during 2014/15 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% (March 2015) for admitted patient care
  - 99.9% (March 2015) for outpatient care
  - 99.0% (March 2015) for accident and emergency care

- Which included the patient’s valid General Medical Practice Code was:
  - 100% (March 2015) for admitted patient care
  - 99.9% (March 2015) for outpatient care
  - 100% (March 2015) for accident and emergency care

Payment by results

Southend University Hospital NHS Foundation Trust was not subject to the Payments by Results clinical coding audit during 2014/2015 by the Audit Commission.

Quality of data

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

- Continue roll out of noteless clinics.
- Continued provision of training to staff on data quality and verification checks.
- Sustained data verification work between clinical coding staff and healthcare professionals.

Information Governance

Southend University Hospital NHS Foundation Trust’s Information Governance Assessment Report overall score for 2014/15 as measured by the Information Governance Toolkit was 77% and was graded satisfactory (green). However our internal auditors have been unable to validate this and a number of actions have been agreed to give this assurance going forward.
Part Two: Reporting against core indicators:

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.

Since 2012/13 NHS Foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social care Information Centre (HSCIC). Where available from the HSCIC we have shown a comparison of numbers, percentages, values, scores or 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>Value</th>
<th>Expected</th>
<th>Banding</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2013</td>
<td>31/03/2014</td>
<td>1.040</td>
<td>1.000</td>
<td></td>
<td>Within Expected</td>
<td>92/141</td>
<td>1.197 BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>0.539 (THE WHITTINGTON HOSPITAL NHS TRUST)</td>
</tr>
<tr>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>1.020</td>
<td>1.000</td>
<td></td>
<td>Within Expected</td>
<td>74/142</td>
<td>1.169 (BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST)</td>
<td>0.652 (THE WHITTINGTON HOSPITAL NHS TRUST)</td>
</tr>
</tbody>
</table>

Prescribed Information

(a) the value and banding of the summary hospital-level mortality indicator (“SHMI”) 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. Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Regular quarterly reports are produced by the information team and monitored by the clinical assurance committee and the clinical quality review group.
- A more detailed analysis of each quarterly SHMI result is undertaken to identify any outliers in terms of performance at specialty, consultant or procedure level.
• Patient-level clinically based audits are undertaken where necessary to identify any procedural, systemic, or clinical care anomaly which needs to be addressed.

• The SHMI is reported to the trust board on a regular basis as part of our integrated performance board report (IPBR).

Southend University Hospital NHS Foundation Trust intends to take the following actions to improve the indicator and the quality of its services by:

• Further embedding the work of the mortality review group, this group will continue to undertake a review of all unexpected deaths to establish learning for improvements in the future.

**Reporting of Patient Reported Outcome Measures (PROMS):**

**Groin Hernia**

<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>01/04/2013</td>
<td>31/03/2014</td>
<td>0.096</td>
<td>0.083</td>
<td>29/116</td>
<td>0.039 (THE DUDLEY GROUP NHS FOUNDATION TRUST)</td>
<td>0.132 (WYE VALLEY NHS TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>0.058</td>
<td>0.080</td>
<td>119/132</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>

**Hip Replacement Primary**

<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>01/04/2013</td>
<td>31/03/2014</td>
<td>0.408</td>
<td>0.426</td>
<td>105/133</td>
<td>0.342 (ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST)</td>
<td>0.483 (CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST)</td>
</tr>
<tr>
<td></td>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>0.423</td>
<td>0.428</td>
<td>81/136</td>
<td>0.319 (THE WHITTINGTON HOSPITAL NHS TRUST)</td>
<td>0.537 (LEWISHAM AND GREENWICH NHS TRUST)</td>
</tr>
</tbody>
</table>
Knee Replacement Primary

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2013</td>
<td>31/03/2014</td>
<td></td>
<td>0.306</td>
<td>0.315</td>
<td>95/135</td>
<td>0.215 (HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST)</td>
<td>0.400 (NORTHAMPTON GENERAL HOSPITAL NHS TRUST)</td>
</tr>
<tr>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td></td>
<td>0.250</td>
<td>0.311</td>
<td>132/136</td>
<td>0.208 (WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST)</td>
<td>0.375 (ISLE OF WIGHT NHS TRUST)</td>
</tr>
</tbody>
</table>

Prescribed Information

- Groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee replacement surgery, during the reporting period.

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. Therefore, the data included is for the last full year and is not the latest information available but provides a more robust comparison of year on year performance. It should be noted that a higher figure for national average indicates a better performance. It should also be noted that, nationally, no data is available on hip replacement, knee replacement or varicose veins.

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

- Changing 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:

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>01/04/2011</td>
<td>31/03/2012</td>
<td></td>
<td>6.59</td>
<td>10.04</td>
<td>4/49</td>
<td>13.58 (NORTH CHESHIRE HOSPITALS NHS TRUST)</td>
<td>5.10 (THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST)</td>
</tr>
</tbody>
</table>

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>01/04/2011</td>
<td>31/03/2012</td>
<td></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>01/04/2010</td>
<td>31/03/2011</td>
<td></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>

Prescribed Information

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.

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

There is currently no national readmissions data available since 2011/2012. The Health and Social Care Information Centre (HSCIC) have confirmed that the publication of these indicators has been delayed this year and it is unlikely that they will be published during 2014/2015.

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

- 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 2015/16.
The trust’s responsiveness to the personal needs of its patients during the reporting period.

<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>2013-14</td>
<td>68.3</td>
<td>68.7</td>
<td>74/156</td>
<td>54.4 (CROYDON HEALTH SERVICES NHS TRUST)</td>
<td>84.2 (THE ROYAL MARSDEN NHS FOUNDATION TRUST)</td>
</tr>
<tr>
<td>2012-13</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>
</tbody>
</table>

Prescribed Information

The data made available and covering services for inpatients and patients discharged from A&E (types 1 and 2). (Gateway reference 00931)

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

- We actively survey patients following their discharge in relation to the national Friends and Family test. We have exceeded the target that we set to receive feedback from our patients in both A&E and in-patients. All comments received via the Friends and Family surveys are shared with the relevant teams, and changes that are implemented are displayed as “you said, we did” in the relevant ward areas.

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

- Continuing to use technologies such as text messaging and interactive voice messaging. This has proven successful in increasing the response rate and work is in place to further develop how we improve the outcome of these scores by making changes to practice following the feedback from our patients.
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>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>61</td>
<td>65</td>
</tr>
<tr>
<td>2013 survey</td>
<td>67.0</td>
<td>68</td>
</tr>
<tr>
<td>2012 survey</td>
<td>68.0</td>
<td>65.0</td>
</tr>
</tbody>
</table>

Prescribed information

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.

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

The results of the 2014 NHS staff survey were reported to the trust board on 25 March 2015. The trust undertook a further engagement with staff during 2014 through focus groups and as a result has recommended an approach for 2015.

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

Our proposal for using the staff survey results to improve staff engagement during 2015 is to clearly make the link between how staff feel and perform and the impact on the patient experience, as highlighted in Paul Gilbert’s book on care and compassion, Mindful Compassion 2013. We know that staff feel engaged when their voice has been heard and the organisation demonstrates it is willing to take action which increases staff’s confidence to offer ideas, solutions and having their say. The detail of our proposal is that each clinical director is responsible for taking action on staff survey results for their area in the following ways:
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Action</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Annually  | Each clinical directorate analyses their staff survey results to identify:  
- 2 key areas of concern  
- 2 key areas where there are positive responses (celebrating success) | Clinical director/HR Business partner |
|           | Draft action plan that addresses the areas of concern, highlighting how they plan to improve the issues raised | Clinical director/HR Business partner |
| Monthly   | Report on progress (and achievements) at the executive team meeting, making links to feedback received from patient experience & Friends & Family  
Cascade of progress to teams following executive team meeting | Clinical director/HR Business partner |
| Quarterly | Friends and Family staff questionnaires electronically completed via staffnet/other appropriate delivery methodology  
Clinical directorates receive their results  
Each area reviews and incorporates any additional actions into their action plan, feeding back to the executive team meeting | Learning and OD  
Learning and OD  
Clinical director/HR Business partner |
| 6 monthly | Pulse Survey consisting of 2 or 3 questions, selected by the executives on something topical, meaningful or relevant at that time to gauge trust's atmosphere | Executive team and corporate management team |

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1 Mindful Compassion; Professor Paul Gilbert & Choden. Robinson. May 2013

Communicate - Communicate - Communicate - Communicate - what staff say - what have we done - what we’ve improved - what patients say
### Measurement of VTE

<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>01/10/2014</td>
<td>31/12/2014</td>
<td>95.8%</td>
<td>95.9%</td>
<td>93/160</td>
<td>81.2% (CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST)</td>
<td>100% (Various trusts)</td>
</tr>
<tr>
<td></td>
<td>01/07/2014</td>
<td>30/09/2014</td>
<td>95.5%</td>
<td>96.1%</td>
<td>116/162</td>
<td>86.4% (NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST)</td>
<td>100% (Various trusts)</td>
</tr>
</tbody>
</table>

### VTE Return – Data Submissions

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Risk Assessments</th>
<th>Number of Admissions</th>
<th>% Compliance</th>
<th>Date of Submission</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-14</td>
<td>5659</td>
<td>6101</td>
<td>92.76%</td>
<td>28/04/2014</td>
<td>95%</td>
</tr>
<tr>
<td>May-14</td>
<td>5884</td>
<td>6294</td>
<td>93.49%</td>
<td>27/06/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Jun-14</td>
<td>6107</td>
<td>6393</td>
<td>95.53%</td>
<td>27/06/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Jul-14</td>
<td>6515</td>
<td>6829</td>
<td>95.40%</td>
<td>28/08/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Aug-14</td>
<td>5836</td>
<td>6096</td>
<td>95.73%</td>
<td>29/08/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Sep-14</td>
<td>6176</td>
<td>6485</td>
<td>95.24%</td>
<td>22/10/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Oct-14</td>
<td>6449</td>
<td>6744</td>
<td>95.63%</td>
<td>28/11/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Nov-14</td>
<td>6208</td>
<td>6435</td>
<td>96.47%</td>
<td>05/01/2014</td>
<td>95%</td>
</tr>
<tr>
<td>Dec-14</td>
<td>6085</td>
<td>6375</td>
<td>95.45%</td>
<td>28/01/2015</td>
<td>95%</td>
</tr>
<tr>
<td>Jan-15</td>
<td>6022</td>
<td>6279</td>
<td>95.91%</td>
<td>28/01/2015</td>
<td>95%</td>
</tr>
<tr>
<td>Feb-15</td>
<td>5880</td>
<td>6146</td>
<td>95.67%</td>
<td>30/03/2015</td>
<td>95%</td>
</tr>
<tr>
<td>Mar-15</td>
<td>6505</td>
<td>6811</td>
<td>95.51%</td>
<td>28/04/2015</td>
<td>95%</td>
</tr>
</tbody>
</table>
Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

The trust’s VTE risk assessment compliance is monitored by an established and thorough audit process. Every month, before submission of risk assessment data, notes are checked for non-compliant admissions. In the majority of cases, it is found that a risk assessment had been completed, but error had occurred recording it on the patient administration system (PAS). For these cases, PAS is updated to show the correct information. Cases confirmed as having no risk assessment, are recorded and monitored to see if there is an on-going issue in any particular area, or if it is a one-off error. On-going problem areas are reported back to the VTE steering group, and followed up by the VTE link nurse and clinical directorate.

Additional to this specific risk assessment audit, the audit department perform spot checks on general VTE performance. They audit 10 random admissions on a selection of wards each month, to make sure risk assessment was completed – and that recommended prophylaxis was given.

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

- Raising awareness with staff, auditing and closely monitoring compliance so that any practice issues can be identified and addressed. Training has been put in place to improve performance; this has included running a VTE study day and introducing an e-learning package.
- Reviewing data transfer processes to make sure 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, clinical directors and associate clinical directors to inform additional actions required to improve performance.
- Providing a prompt, system of recording confirmation of assessment and intervention, with alerts which flag delays or non-compliance and runs “live” compliance reports.

Measurement of C difficile cases:

<table>
<thead>
<tr>
<th>Period</th>
<th>From</th>
<th>To</th>
<th>Value</th>
<th>Nat Avg</th>
<th>Rank</th>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2013</td>
<td>31/03/2014</td>
<td>17.8</td>
<td>14.7</td>
<td>121/160</td>
<td>37.1 (University College London Hospitals)</td>
<td>0.0 (Several trusts)</td>
<td></td>
</tr>
<tr>
<td>01/04/2012</td>
<td>31/03/2013</td>
<td>13.4</td>
<td>17.4</td>
<td>50/160</td>
<td>31.2 (Imperial College Healthcare)</td>
<td>0.0 (Several trusts)</td>
<td></td>
</tr>
</tbody>
</table>
**Prescribed information**

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.

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

It is apparent that there are indications that the level of Clostridium infections may be approaching their irreducible minimum level and these cases will occur, due to some people carrying C difficile in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. These are factors outside the control of the NHS organisation. Following each episode of a patient being identified with Cdifficile in the trust a full root cause analysis is undertaken. The outcome of these has shown that for the cases that have occurred during the reporting period only one case was avoidable.

<table>
<thead>
<tr>
<th></th>
<th>Qtr 1</th>
<th>Qtr2</th>
<th>Qtr3</th>
<th>Qtr4</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-Diff in Qtr</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>OBD for Qtr</td>
<td>45920</td>
<td>46427</td>
<td>46575</td>
<td>46720</td>
</tr>
<tr>
<td>Ratio Per 100,000 OBD</td>
<td>10.89</td>
<td>17.23</td>
<td>17.18</td>
<td>14.98</td>
</tr>
</tbody>
</table>

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

As part of the on-going C difficile reduction programme in the trust, the C difficile policy was refreshed and updated in July 2014 with increased emphasis on

- Prudent antibiotic prescribing
- Raised awareness of the use of the Bristol stool chart and prompt isolation of suspected cases
- Environmental cleaning

The infection prevention and control team (IPCT) continue to operate a system of scrutiny of all C difficile tests before laboratory processing with the aim of:

- Reducing unnecessary or inappropriate requests
- Identifying patients of concern for early assessment and intervention
- Providing feedback to wards and clinicians over request patterns
- Preventing inadvertent repeat testing of known positive isolates
Measurement of patient safety incidents:

<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>14-15</td>
<td>9205 (44.32 by 1000 bed days)</td>
<td>48</td>
<td>0.5%</td>
</tr>
<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>

Prescribed information

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.

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

This data identifies an increase in the reported patient incidents per bed day and therefore demonstrates that staff have confidence in the local reporting system and use it to notify senior managers of incidents that are occurring, including near misses, within the trust. Barriers to report incidents have been identified and removed and staff are not blamed or punished when they report incidents. Staff feel comfortable to report incidents, a process that is easy to do, whatever the severity of harm, rather than something that may only happen when a serious incident occurs.

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. Encouraging 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.
Southend University Hospital NHS Foundation Trust has taken the following actions to improve this number and/or rate, and 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
- The governance team undertake a periodic review of comparative incident reporting data in relation to other similar sized organisations within the Essex County to determine if we are consistent in our reporting
- The team also undertakes a breakdown of type and severity of incidents reported trust wide including a measure of profile by directorate and staff groups
- The trust-wide distribution of a weekly incident round-up to feedback on recent incidents and lessons learned and to encourage reporting rates amongst all staff, doctors and other allied health care professionals
- The governance team also participate in the mortality and morbidity reviews to make sure recommendations are implemented
- Members of the governance team attend directorate 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

NHS foundation trusts must specifically use Part 3 of the quality account to present an overview of the quality of care offered by the NHS foundation trust based on performance in 2014/15 against indicators selected by the board in consultation with stakeholders.

The indicators set must include

- At least three indicators for patient safety
- At least three indicators for clinical effectiveness and
- At least three indicators for patient experience.

The quality indicators for 2014/15 were chosen following a week-long road show engaging with our patients, their carers, our foundation trust members, governors and our staff to determine what was important. The indicators were approved by our trust board.

The quality of care indicators chosen describe the quality for improvement indicators for 2015/16 in part 2 of the quality account. These remain unchanged from 2014/15 which provides the foundation of the care provided to our patients.

Patient safety 2014/15

World Health Organisation (WHO) checklist

This indicator was first made a priority for inclusion in the quality account by the trust for 2014/15. During the past year we have achieved 100% compliance with the spot check audits undertaken by the matron and governance lead in theatres, with the average reporting on the data base for all WHO checklists being at 99.9% on the Sapphire theatre system.

What have we achieved this year?

The compliance with the WHO checklist is further evidenced by having no reportable ‘Never’ events for the reporting period.

The robustness of the checks has been the key to preventing issues identified as part of the process of the checks for the WHO checklist.

These include

- Wrong site markings
- Incorrect data recorded on theatre system
- Patient alerts not recorded
- Identification errors i.e. hospital numbers/ dates of birth incorrect
- Allergies not recorded

Next steps

We will continue to make sure that staff are trained in undertaking the WHO checklist and that the process is audited both by spot checks and from the trust theatre system.
Early warning system

Percentage of ward compliance

<table>
<thead>
<tr>
<th></th>
<th>Aug-Dec 2012</th>
<th>Jan-Dec 2013</th>
<th>Jan-Dec 2014</th>
<th>Jan/ March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of new referrals with a complete set of vital signs</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>75-89%</td>
<td>62-92%</td>
<td>86-95%</td>
<td>90-97%</td>
</tr>
<tr>
<td>% of timely referrals to Outreach</td>
<td>86-95%</td>
<td>67-92%</td>
<td>86-97%</td>
<td>86-95%</td>
</tr>
<tr>
<td>% of timely patient transfer to critical care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

What have we achieved this year?

The care of deteriorating patient within Southend University Hospital NHS Foundation Trust is being led clinically by the associate medical director.

The work that has been undertaken in this area during 2014-2015 includes:

- All qualified nursing staff in ward areas have received SBAR (Situation Background Assessment Recommendation) training.
- The introduction of a sepsis protocol for patients who present with sepsis. This is now in place in A&E. The process is being audited using patient data collection forms. Liaison is now taking place with the oncology department to include oncology patients who present with sepsis in this protocol.
- The roll out of Treatment Escalation Plans (TEP) has now been implemented in all inpatient clinical areas.
- The implementation of the National Early Warning System (NEWS). This is currently being implemented within all inpatient areas with full support and monitoring from the outreach team. The aim is to have this fully embedded by the end of May 2015.
- A successful bid to the Nursing Technology Fund for an electronic clinical observation recording tool (Nerve Centre). A project team has been convened and completion of the project is estimated for approximately 12 months’ time.
- On-going work on our AKI (Acute Kidney Injury) management project. Led by the renal consultants with input from the critical care outreach team. The first 150 patients have had an AKI pro-forma alert put in their records. Further feedback is awaited on how we progress this further which will inform our next steps.

All of the above supports the trust’s work in the identification and management of the patient at risk of deterioration.
Duty of candour

2014/15 performance

In 2014/15 we have exceeded our target of 85% throughout the year.

What have we achieved this year?

The trust has made significant improvements on how the duty of candour is met. The above target was agreed following our contractual requirements; however, the duty became statutory on the 27th November 2014 and now requires the trust to go beyond this and include patient safety incidents that result in moderate harm and prolonged psychological harm and follow up the verbal notification with a written notification. We are required to be open and transparent with the ‘relevant person’ when certain incidents occur, advising what the incident was and provide them with the necessary support. This includes an apology that the patient safety incident occurred. This verbal notification is then followed up by giving the same information in writing and is sent directly from the trust’s medical director.

Next steps

We will continue to measure to make sure that the trust is being open and honest when an incident occurs. For the forthcoming year we have increased our target of compliance to be in 100% of applicable cases in line with statutory guidance.
Clinical effectiveness 2014/15

Make sure nursing skill mix is safe and appropriate to caseload

This indicator was first made a priority for inclusion in the quality account by the trust for 2014/15. Currently performance information is only available for the current year and achievements are detailed below.

What have we achieved this year?

The requirement to report nurse staffing levels to the Department of Health has been complied with. Reports on the actual staffing levels in comparison to the planned staffing levels for each ward have been submitted to the trust board and published on the trust’s website in accordance with the schedule set by NHS England. These reports have met the reporting guidance set out in the National Quality Board (NQB) (2013) publication “How to make sure the right people, with the right skills are in the right place at the right time.” Both NHS England and the CCG have been assured that the trust is complying fully with the reporting requirements.

Nursing Staffing Workforce Review 2014

In the reporting period an extra 69.48 Registered Nurses and 3.12 Health care assistants were agreed by the trust board.

Close management is undertaken on a shift by shift basis and where there are high risk triggers identified these are then mitigated, it was reported to the trust board on 25 March 2015 that in January and February 2015 the most up to date reporting period, that all of the high level risks were mitigated with the actions taken. In addition to this to further support the staffing levels senior professional nursing cover (duty matron) was increased to go across the seven days of the week from the 2 February 2015.

We developed a policy to provide guidance on the assessment, management and escalation of adverse nurse staffing situations which is available to all staff.

Next steps

• We will continue to monitor and report our staffing levels as we have done for the current reporting period with close management of staffing levels on a shift-by-shift basis.
• We will be updating our electronic rostering system in April 2015 will allow more effective real-time reporting of how we use our workforce.
• Monthly reports of nursing staffing levels will continue to be submitted and published in accordance with national guidance
• Six-monthly staffing and skill mix reviews of the nursing staff workforce will be undertaken based on using the Safer Nursing Care Tool (SNCT), other available tools and professional judgement. The next review is under way at the present time and this will be presented to the trust board in May 2015.
• Initiatives continue to recruit more staff, with plans to recruit from Europe.
62-day target for cancer waits

2013/14 Performance

2014/15 Performance

2014/15 performance against previous years

The first chart below specifically shows the trust’s performance through the year 2013/14 against our internal 90% target for Southend only pathways. 2014/15 saw an agreed amendment to our internal target to 80%, and the second chart below illustrates our performance against that target.

What have we achieved this year?

We realise that this continues to be a significant challenge for us particularly with our Urology services. An action plan for our 62-day target has been in place and we recognise that this needed to be updated.

Next steps

- A revised cancer recovery plan has been finalised. This will target the 2/3 most significant issues across our most challenged tumour sites.
- Weekly teleconference calls have been arranged with Basildon and Broomfield Hospitals to highlight any urgent referrals that require escalation.
- A second brachytherapy team has been provisionally agreed, and was due to start work early March effectively doubling capacity.
- A capacity and demand plan is underway in oncology aimed at addressing the shortfalls in the joint oncology clinics.
Four-hour accident and emergency target

2013/14 performance

A&E 4 Hour Target Performance

2014/15 performance

A&E 4 Hour Target Performance
What have we achieved this year?

We had a very positive start to the year achieving the four-hour target for five consecutive months, narrowly missing quarter 1 with 94.14% but comfortably achieving quarter 2 with 96.25%. Despite winter pressures, we have maintained good progress towards the four-hour target. Although not achieving quarter 3, we have consistently been one of the best achieving trusts in Essex. We also have been one of the best performing trusts in relation to ambulance turnaround times this year in Essex. We have very successfully created our Rapid Assessment and Treatment (RAT) team this year which has improved our service greatly within the ED. The team include senior decision makers who rapidly see and treat patients in the department, achieving early treatment and diagnosis in order for the patient to move in a timely manner through the emergency pathway. We have also opened our paediatric emergency department, an audio and visually separate, comfortable unit for children and young people to be seen and treated. Our majors and minors areas within the main ED have been expanded creating two extra majors cubicles and three extra minors cubicles. We have also welcomed our senior advanced care practitioner who started with us early 2015.

Next steps

There is still significant work to be completed as part of the Emergency Care Improvement Plan – specifically around bed modelling and speciality pull. We remain committed to our workforce plan particularly with regard to increasing and recruiting substantive consultants. We have taken our first steps towards looking to the future in the form of Advanced Care Practitioners (ACPs). We have our senior ACP within the ED team and are beginning to create the pathway for our future ACPs. We are starting to see a consistent increase in daily attendances and will strive to look at ways to adapt and improve our ED pathways.
Patient experience 2014/15

Patient feedback

What have we achieved this year?

We have ensured that the Friends and Family test is available in all inpatient wards, A&E, maternity and outpatient areas. More recently we introduced an ‘easy read’ Friends and Family survey for patients with learning disabilities and also a survey for children and young people.

We recognised through the year that we were not achieving our desired levels of feedback so looked at what other initiatives we could offer for patients to give us their feedback and increase our response rate. We now collect the data in three ways: postcard surveys, phone surveys (IVM, interactive voice message) and text messaging.

From this we have developed the ‘You said, we did’ slogan within Friends and Family test comments and positive comments received are placed on a ‘comments’ board available for staff and patients to see. Any constructive or negative comments are sent to the area with an action plan to report back.

Also, a monthly patient experience feedback tool has been devised with all feedback including Friends and Family test comments, mystery shopper and web feedback. This information is sent out on a monthly basis for each clinical directorate to review, and any actions made as a result are communicated to the patient experience team.

The patient experience team monitor the ‘patient opinion’ and ‘NHS choices’ websites daily and feedback key issues to the clinical directorates. We have noticed through good communication, small changes can make a big difference to patient experience.

Next steps

We have extended the text messaging and interactive voice message service to reach more patients including all Outpatient areas and Day cases.

We have also further scoped the patient survey to include children and young people developing an easy read survey asking the question to obtain feedback from under 16’s ensuring we are inclusive and can make changes to children services as well as adult.

Wards and departments are able to learn from service user comments being able to view and share with staff to make changes and celebrate good practice as a result of the feedback received.

A quarterly Patient and Carer service improvement focus group is held - The aim of this group is to give patients and carers the opportunity to be consulted and comment on major service improvements being made by the trust. The groups will draw upon patients and carers using all areas of the trust to provide a balanced overview and allow us to consult as widely as possible.

Patient focus groups

What have we achieved this year?

We have further developed our trust-wide patient focus group with the first meetings taking place this year; the group meets quarterly and is made up of representatives from staff, patients and their carers. So far the group has taken a view on the following service improvements: pharmacy self-administration of medication, electronic correspondence and text appointment reminders, and made recommendations for the trust staff during implementation.

Next steps

The work plan for the focus group is to make sure that they work collaboratively with the directorate focus groups to make a difference to the services that the trust provides and make sure that these are led by involvement with our patients and their carers.
**Education and development programmes for all levels of staff**

**What have we achieved this year?**

As part of all new healthcare assistant inductions, we have built in our values and customer experience sessions.

As part of the induction programme for nurses recruited from the European Union we built in values and customer experience sessions and will do the same when we induct our nurses from other overseas recruitment events.

Throughout 2014 to 2015 our values have been weaved into all new programmes and we have newly designed activities, such as podcasts and webinars.

Our programmes are developing all the time - including e-Learning; podcasts or webinars - alongside face to face sessions. We have recently launched three new leadership programmes following a successful pilot.

We have carried out a complete review of the statutory/mandatory training to make sure it meets the needs of the organisation. Working with management teams to preserve staff's time to care for our patients and operate in a safe and risk free environment.

We have started delivering on our vision that all Bands 1 to 4 (circa 2000 staff) are offered at least one piece of personal skills development per year. We have launched the manager's toolkit providing tools, support and guidance for all managers. Alongside we have launched a new manager's programme so that newly appointed managers - whether internal or external- have access to all the information they need at their fingertips to make their transition as smooth as possible.

Following our Bands 1 to 4 event in November we are holding another event in April 2015

The outcome of the conference will be to:

- Reward and thank staff for their contribution
- Build awareness of the different roles within this population group
- Develop skills and knowledge aligned to our values
- Create an environment where we can get the group to generate ideas for making the patient experience better
- Build networks across the organisation to support each other

**Next steps**

In April 2015 we are launching the clinical directorate Leaders programme. This programme is a six-month programme of facilitated sessions, 360 Feedback tools, expert internal speakers, external speakers, actor participation to develop skills and coaching from an external organisation.

**Two key improvements:**

It was recognised that the lowest compliance was found in two key staff groups: volunteers and domestic staff. Working with the service managers, 15 bespoke sessions (over a four month period) were scheduled to suit the service requirements which increased our compliance from 0% to 75% for Volunteers and 12% to 68% for domestic staff.

The Learning and Organisational Development team are looking to schedule a number of voluntary events, where participants can gain a first-hand experience of what it might be like to undergo life with a protected characteristic – one proposal is engaging the Royal National Institute of Blind People to lead an ‘in the dark’ event. The aim is that these events will create a greater interest to and understating of diversity awareness.

Additionally, it is intended that inclusivity and collaborative working is achieved through bespoke learning interventions. For example, an equality and diversity portal will be designed on iLearn, so that staff can access articles, videos, act guidance and mini-byte development at the point of need.
Performance against 2014/15 key national priorities

The trust continues to review the services it provides, and the systems and processes that support them, in order to make sure 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% four-hour standard and the 62-day cancer referral to treatment target.

A system wide review of the urgent care pathway is underway with the CCG and area team which will introduce significant change to the urgent care patient pathway and will address historical poor practices.

For the 62-day cancer target, individual tumour site pathway reviews have started with a view to removing any unnecessary processes. A cancer board has been established which is clinically-led.

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 people to whom the provider has provided relevant health services during the reporting period for comment before publication and we include these comments as follows.

Annexes:

- Comments (obligatory) from commissioners
- Comments (voluntary) from Southend-on-Sea – Borough Council (OSC)
- Comments (voluntary) from governors’ patient and carer experience group
- Statement of directors’ responsibilities in respect of the quality account
- External auditors’ limited assurance report
## Monitor Risk Assessment Framework - 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>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></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>
<td>90.2</td>
<td>85.1</td>
<td>83.5</td>
<td>89</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>
<td>96.0</td>
<td>94.9</td>
<td>93.3</td>
<td>95.5</td>
</tr>
<tr>
<td></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>
<td>93.0</td>
<td>92.6</td>
<td>93.4</td>
<td>95</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>
<td>94.1</td>
<td>96.3</td>
<td>92.4</td>
<td>93.6</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>
<td>81.7</td>
<td>79</td>
<td>78.2</td>
<td>82</td>
</tr>
<tr>
<td></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>
<td>96.5</td>
<td>97.9</td>
<td>90.7</td>
<td>96.7</td>
</tr>
<tr>
<td></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>
<td>97.0</td>
<td>94.6</td>
<td>93.9</td>
<td>87.2</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>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
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</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>
<td>99.4</td>
<td>99.7</td>
<td>99.0</td>
<td>99.0</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>97.0</td>
<td>99.3</td>
<td>99.7</td>
<td>99.4</td>
<td>99.0</td>
<td>98.6</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>
<td>97.8</td>
<td>97.9</td>
<td>96.8</td>
<td>97.1</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>
<td>93.7</td>
<td>95.0</td>
<td>95.1</td>
<td>95.2</td>
</tr>
<tr>
<td>Access</td>
<td>Cancer: 2-week wait from referral to date first seen comprising 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>
<td>91.7</td>
<td>96.1</td>
<td>98.6</td>
<td>97.9</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Clostridium (C.) difficile - meeting the C. difficile objective</td>
<td>de minimis applies</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</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></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
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</table>
NHS Southend CCG commentary on Southend University Hospitals NHS Foundation Trust 2014/15

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.

The CCG is pleased to note that the trust’s current registration status with the Care Quality Commission is ‘unconditional’ and no enforcement action has been taken against the trust during this period. Further to the visit by the CQC in August 2014, the CCG was supportive of the action plan, which was developed when the trust was found to be non-compliant for 3 regulations, progress against this plan is monitored through the monthly Clinical Quality Review Groups (CQRG).

The trust recognises that there have been challenges during the year particularly for acute trusts following the publication of the Francis and Berwick Reports. In addition, relating to compliance with the four hour standard for patients to be seen in the Emergency Department and the 62 day cancer targets. The CCG has been working closely with the trust to optimise their performance and ensuring that patient safety is assured. The CCG is aware that the trust has signed up to the ‘Sign Up for Safety Campaign’ and the CCG will be working through the CQRG to monitor progress with the initiatives.

The CCG notes the trust’s key priorities for 2015/16 which will continue to build on the following themes:

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

**Patient Experience**
- Patient Feedback
- Patient Focus Groups
- Education and development programme for staff at all levels

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

The CCG notes the trust’s comprehensive clinical audit and research programmes for 2014/15 and would welcome the sharing of outcomes linked to key areas of improvement or challenge, through the CQRG Meeting forum.

The CCG notes that during 2014/2015, SHMI increased to 1.040 which is above the expected of 1.000. The ranking nationally has dropped to 92/141 from 74/141 (2012/13). The trust will be taking actions to further embed the work of the Mortality Review Group in the review of all unexpected deaths to establish learning for improvements in the future.

It is noted that the current data for C.Difficile performance is not included in the quality account while recognising that the CCG is aware that the trajectory for 2014/15 was breached (28/26), there continues to be robust trust and CCG infection control monitoring of all investigation reports. In addition there was 1 true MRSA bacteraemia and 1 contaminant against a zero tolerance agenda the investigation report is shared through the Infection Other information - Annexes
control network meeting to optimise opportunities for learning through these incidents.

The CCG notes the trust’s achievements against the 2014/15 priorities which include the following outcomes:

**Patient Safety**

**World Health Organisation (WHO) checklist**

- Achieved 100% compliance with spot check audits and no reported ‘Never Events’
- Early Warning System
- All nursing staff have received SBAR training
- The use of the sepsis protocol has been embedded in the Emergency Department
- The implementation of the MEWS Early Warning System is expected to be embedded by May 2015

**Duty of Candour**

- The initial guidance on Duty of Candour was published and the trust set an 85% compliance target which has been achieved. The CQC guidance went live in November 2014 and the trust has increased its target compliance to 100%.

**Patient Experience**

**Patient Feedback**

- Introduction of an easy read Friends & Family survey for patients with learning disabilities and a ‘you said’ ‘we did’ board for patients and staff.

**Patient Focus Groups**

- Enhanced the patient focus group to include service improvements relating to pharmacy, text appointment reminders and a Maternity service user group.

**Education and development programme for staff at all levels**

- Development of programmes including podcasts e-learning and webinars for staff.
- Clinical Effectiveness
- Make sure nursing skill mix is safe and appropriate to caseload
- The trust undertook a nursing workforce review to keep to the safer staffing guidance and continues with monthly reporting.

**62 day ceiling for cancer waits**

- As previously mentioned the trust has experienced difficulties in achieving compliance and there was an agreed amendment to the trust’s target now 85%.

**4 hour accident and emergency target**

- The CCG continues to support the trust to optimise its performance and it is noted that the rapid assessment and treatment team has improved the delivery of the Emergency Department service.

NHS Southend CCG continues to meet regularly with the trust to seek assurance on performance, delivery of care and to make sure 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 2015
Feedback from Healthwatch Southend

Healthwatch Southend response to Southend University Hospital NHS Foundation Trust’s quality account 2014/2015

We would like to thank Southend University Hospital NHS Foundation Trust for inviting us to comment on its quality account 2014/15.

Healthwatch Southend continues to enjoy positive and productive relationships with individual trust staff that have willingly contributed to and engaged with us and the issues we have raised over the last year. Relationships with individuals have strengthened and NHS staff attended and contributed to several of our events notably on Health Checks for people with Learning Disability (July 2014), Access to GPs (August 2014) and Community Dentistry (October 2014). There is further work to be conducted in these particular areas of health care but we feel confident that further improvements can be realised and reported in 2015/2016.

We believe that we enjoy an open relationship with key trust staff and look forward to continuing work around shared concerns and issues with an ongoing spirit of collaboration, cooperation and proactivity throughout 2015/2016. It is also important for Healthwatch to remain responsive to concerns and issues which may be raised by the public individually or informed by our advocacy and advisory service provision. It is our view that where responsiveness is the appropriate reaction, we will be appropriately supported by trust staff.

We systematically collate data from our Complaints Advocacy and Information and Advice services and would be happy to share this specific information on request. It is a legislated obligation of Healthwatch to “enable local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved”. For this reason, a priority for Healthwatch Southend 2015/2016 is to exercise its power to ‘enter and view’ and this may include observing and reporting on services at Southend University Hospital. These visits will be informed by our consumer feedback on issues, concerns and compliments highlighted and conducted by fully trained volunteer representatives. The reason for the visits will be transparent and communicated to the trust before arranging the visit. The respective outcomes will be reported and published with the ultimate aim being to contribute to effecting any requisite change and improvement together with highlighting good practice and negative/positive patient experience.

We can confirm that all of our FOI requests have received prompt responses from the trust and there have been no refusals. This information provided us with answers that broadened our insight into issues affecting the hospital. In turn, we were able to pass this information on to the public via our e-bulletin and social media accounts.

Our comments on the quality account are as follows:

- It is clear that the commitment and responsiveness of hospital staff to the continued pressures has resulted in the progress reported in emergency service provision and we commend the trust for this achievement. However, the challenges remain as does the threat in meeting the 4-hour A&E target which is evidenced in the difficulties in meeting this target in the last two quarters of 2014/15. As noted in our previous response, while we appreciate that the trust reports patient numbers accessing the service to be consistently increasing, we hope that the fundamental factors for performance deficiencies – insufficient numbers of senior staff and physical size of the department – are prioritised and systematically addressed.

- It is of concern that the 62 day cancer target continues to be a challenge and that no significant improvements can be reported. However, we are pleased to hear...
that performance issues are further being addressed with external expertise and an action plan and that monitoring thereof will be a responsibility of the trust board. Cancer services in Southend are a key priority in the work plan of Healthwatch 2015/2016. We will be proactively gathering views and information from a range of consumer sources with the objective of evidencing areas of issue and concern in order to effect improvements in this critical area and as always we will be consistent in reporting good practice in cancer care services too. We look forward to significant improvements being achieved and reported by the trust, and the public, over the coming year.

- We also note that the CQC visit, in response to stakeholder concerns of the service in August 2014, was proactively addressed with an action plan and consequentially identification of poor practice. The fact that no enforcement action has been taken against the trust in 2014/2015 is testament to the dedication of its staff and efficacy of its improved and scrutinised processes.

- We support the trust in remaining attentive and responsive to the main concerns of its stakeholders by continuing with the priorities of the previous year; Patient Safety, Patient Experience, Clinical Effectiveness.

- The progress and achievements in Patient Safety with the WHO checklist, the Early Warning System and Duty of Candour are extremely encouraging and the compliance rates reported are notable. We commend the trust for its achievements in these areas and are confident that continued vigilance together with the consistent review of processes and the implementation of systems will support further improvements and the meeting of targets in these areas.

- **Patient Experience** initiatives also continue to be implemented and embedded across the trust and as a representative consumer voice for health services across the borough, Healthwatch Southend commends developments, successes and future plans in response to this priority and would welcome the opportunity of further collaborating with the trust to support patient involvement in current and future service review and design.

- We have noted our concerns regarding A&E targets and cancer waiting times and will be monitoring Healthwatch consumer feedback received relating to these areas. Gathering the consumer voice on cancer services is a key priority of Healthwatch Southend 2015/16 and we will be planning a range of engagement activities to make sure that we are gathering comprehensive evidence of cancer patient experiences and views to further inform the respective activity of the trust. In addition to these areas of Clinical Effectiveness being addressed, we are pleased to see that there are a number of initiatives having been undertaken or planned to make sure the nursing skill mix is safe and appropriate. Of particular note is the increased senior professional nursing cover across seven days from 2 February 2015.

Debbie Bent  
Interim Healthwatch Manager  
19 May 2015
Feedback from Essex County Council Health Oversight and Scrutiny Committee

The HOSC has sought to provide a critical friend while being supportive to the trust. SUFHT has yet to appear before the HOSC – this will be rectified later in the year. However, a small sub group of the HOSC, that is reviewing complaints handling in acute trusts in Essex has been working with staff from the Complaints Handling and Patient Experience Team at the trust and has also had a discussion with the head Governor of the trust. The new chief executive at Southend has also requested a meeting.

Whilst reviewing the overall impression and messages given in the quality accounts, it was noted that it does have an emphasis on patient experience and national audit, Readmission data and Family and Friends data. Very little in the report refers to the A&E 4 hour target, nor the 62 day patient standard. The report is lightweight on KPIs. It is noted that paediatric separation in A&E has been improved, step down beds increased although there is no evidence of sharing this with ECC SC Teams.

Finally, I think it would be helpful to have included some mention of collaborative working with Adult Social Care, in response to the Care Act and also to have had more information regarding patient experience.

On behalf of the HOSC, may I thank you for the opportunity to comment on these draft accounts.

Jill Reeves
Chairman Essex County Council HOSC
17 May 2015
Feedback from Governors’ patient experience group

Quality account 2014-2015

Response from the Governors’ Patient and Carer Experience Group (PCEG)

2014-2015 has been a period of change for the trust and patient care has benefitted.

Governors were pleased to see the progress in the priorities for patient safety that were set at the beginning of the year:

- The WHO checklist;
- The early warning system;
- The duty of candour.

We appreciate the importance of continuing these priorities, aiming even higher in 2015-2016.

When Governors engage with the members of the trust and the public at meetings in the local area, we ask them about their experiences of the hospital as patients or carers. The majority are full of praise for the care they have received from doctors and nurses. We also ask how the trust could improve and report suggestions to the relevant staff. Similarly when we hold Listening Exercises on hospital premises in various departments people are willing to talk. We are glad that there has been an increase in staffing levels on the wards. Patients often comment on how busy nurses are. Accompanying non-executive directors on their walkarounds to wards and various departments has increased our understanding of staff and patients’ needs. Setting up the Patient and Carer Service Improvement Focus Groups (PACSIFG) within the clinical directorates has been slow.

While we recognise the improvements in many areas, especially in A&E, the PCEG is disappointed that despite considerable effort certain key national priorities have still not been met:

- The 18 week Referral to Treatment (RTT) target;
- The 62 day target for Cancer patients to receive their first treatment after an urgent referral.

The PCEG believe that in measuring trust performance, factors outside trust control such as late referrals from other trusts and cancellations by patients should be clearly identified and their effects properly taken into account.

The Patient Carer Experience group will be following up the planned improvements in the pathways for COPD (Chronic Obstructive Pulmonary Disease) and Care of the Dying.

We hope to see an increase in the number of staff who will recommend the trust to friends and family. The great majority of staff show a high level of commitment and many go beyond their contractual requirements.

Elaine Blatchford
Chair of the Patient and Carer Engagement Group.
19 May 2015
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 2014/15;
- 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 2014 to May 2015
  - Papers relating to quality reported to the board over the period April 2014 to May 2015
  - Feedback from the commissioners dated 29 May 2015
  - Feedback from governors dated 19 May 2015
  - Feedback from Local Healthwatch organisations dated 19 May 2015
  - Feedback from Essex County Council Health Oversight and Scrutiny Committee dated 17 May 2015
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27 May 2015
  - The national inpatient survey published by CQC on 29 May 2015
  - The national staff survey published on 24 February 2015
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 18 May 2015
  - CQC quality and risk profiles dated April 2015
- 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

27 May 2015
Alan Tobias, OBE
Chairman

27 May 2015
Sue Hardy
Chief executive