City Hospitals Sunderland NHS
NHS Foundation Trust

ANNUAL REPORT
2011/12

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NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2011/2012

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

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NHS Foundation Trust

> Our ambition remains to provide best quality and highest safety

YEAR AT A GLANCE

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Inpatients	55,749	56,093[1]	57,778	59,565	57,735	58,761
Daycases	44,012	45,942	51,749	53,246	56,010	61,922
Outpatients (Consultant led – New & Review)	289,127	301,009	314,757	314,562	325,465	334,496
Nurse Led/Allied Health Professional/Midwife Activity	N/A	134,568[2]	147,216	157,944	159,526	160,379
A&E Attendances	102,382	101,285	101,292	112,676	115,388	118,803[3]
Patient Contacts in the Community	212,000	233,161	223,644	225,159	218,319	220,960[4]
Day Care Attendances	6,754	3,722	3,282	4,275	4,454	6,421[5]
Income	£241.22m	£254.52m	£270.24m	£285.64m	£293.94m	£306.02m
Surplus (Deficit)	£0.184m	£5.678m	£1.583m	£1.219m	£2.869m	£3.78m
Average Staff Employed (Headcount)	4,782	4,614	4,863	4,995	4,942	4,973

Notes:

[1] The activity from this year has been identified as spells. Previous Annual Reports have shown the activity as Finished Consultant Episodes.

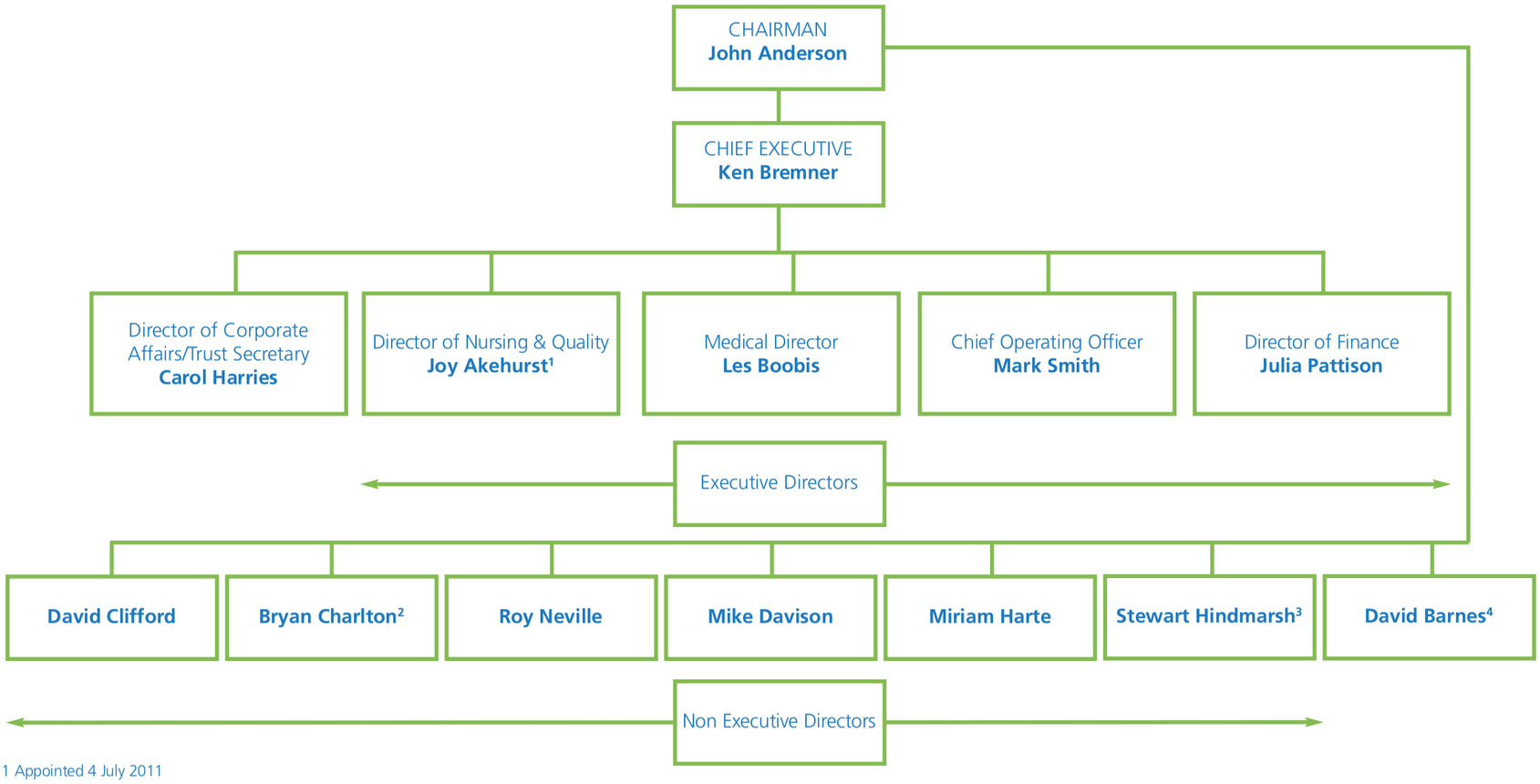
[2] This figure was captured from 2007/08 onwards to reflect the increasing number of patients seen by nurses/midwives and allied health professionals.

[3] Attendances have risen again this year despite the continued investment into primary care services and reflect increased activity over a busy and difficult winter period.

[4] Following a data validation exercise some radiology activity is now reported as an internal issue rather than through direct access.

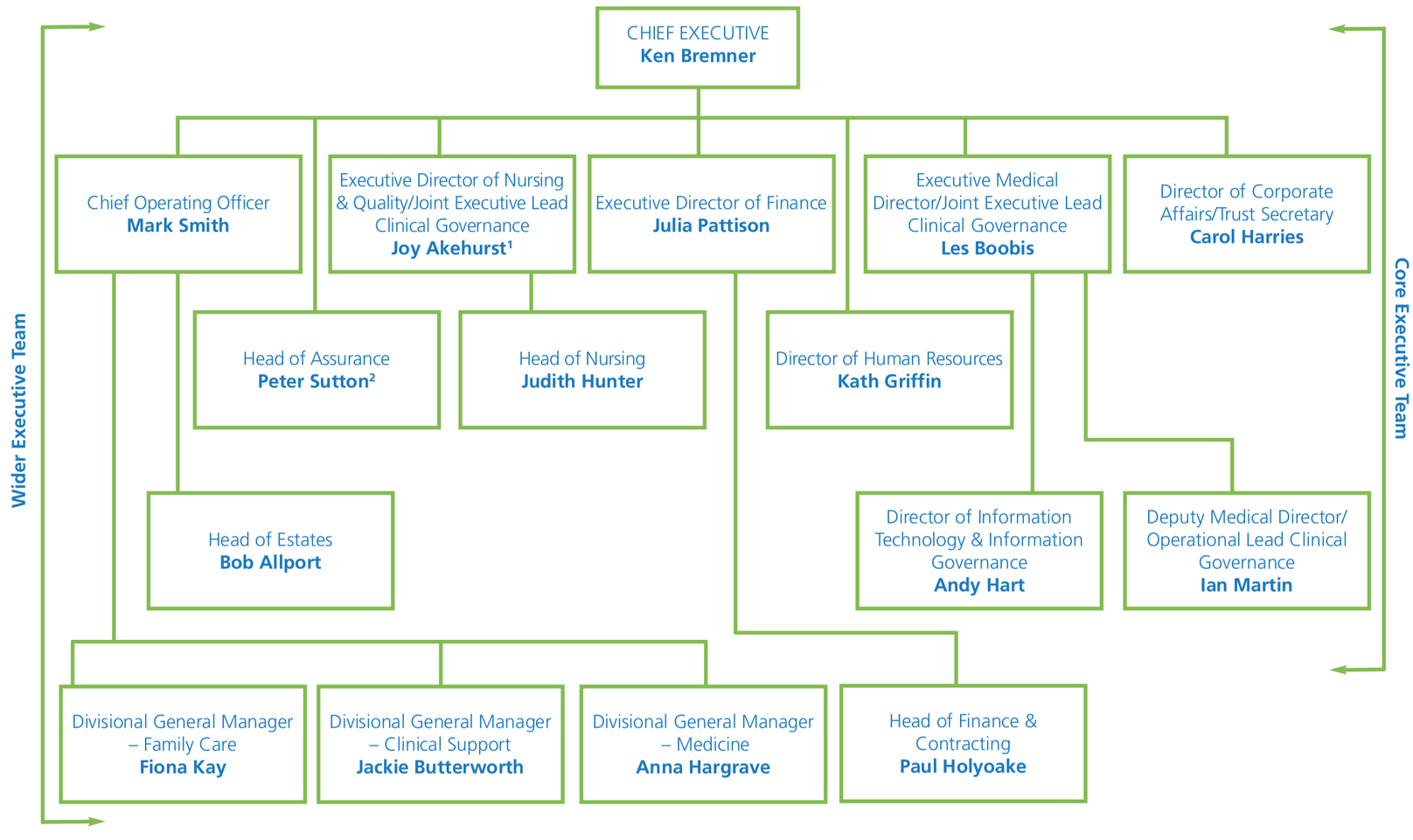
[5] The increase reflects our continued drive to offer more treatments on a daycase basis to prevent patients from having an inpatient stay.

BOARD OF DIRECTORS 2011/12



1 Appointed 4 July 2011
2 Retired 30 September 2011
3 Appointed 1 January 2012
4 Appointed in a 'shadow' capacity from 18 January 2012.

EXECUTIVE COMMITTEE/TEAM 2011/12

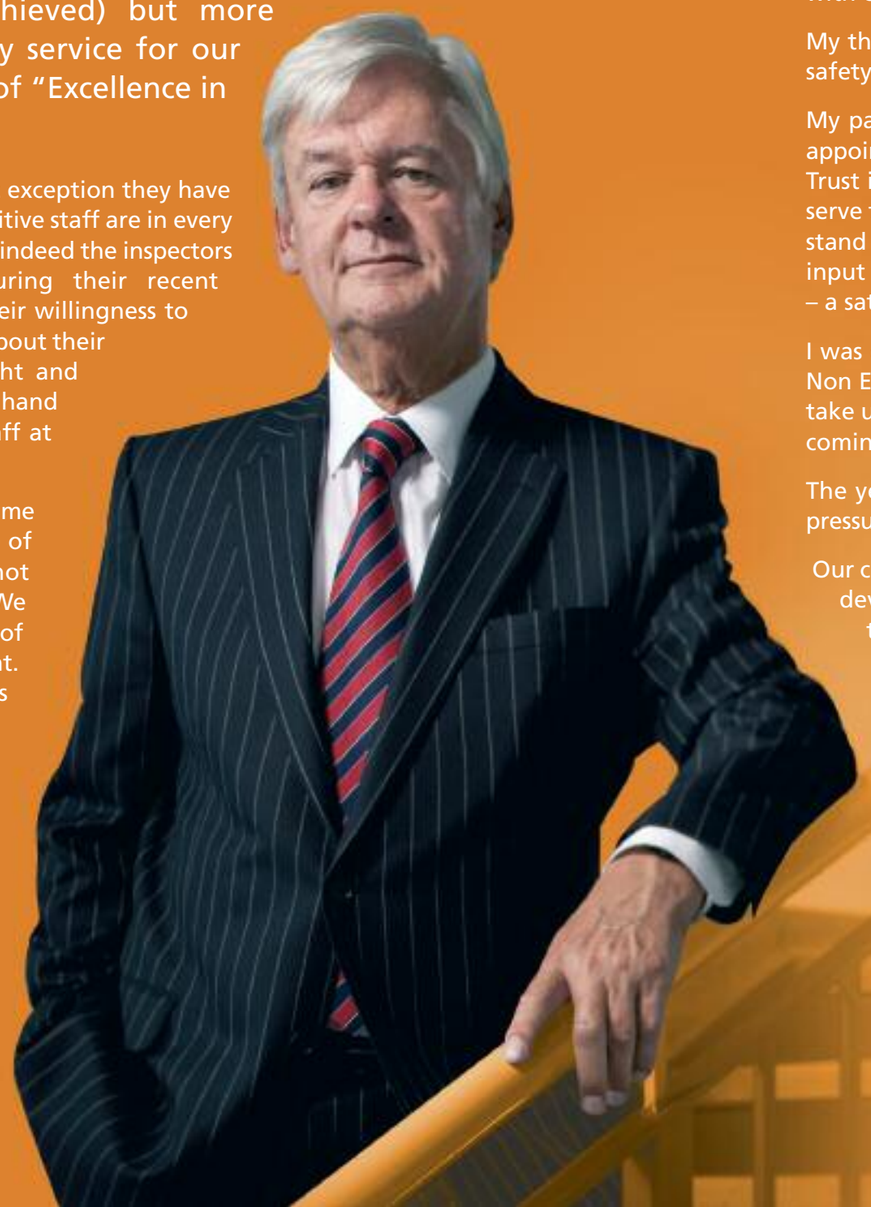


1 From 4 January 2011
2 Until January 2012

CHAIRMAN'S STATEMENT 2011/12

One of the main aims of an Annual Report is to describe what has, and has not been achieved over the preceding twelve months and this report is set out as part of our accountability to our local population and to those who use the services of City Hospitals. The report examines the progress we have made not only against national targets and how we have performed financially, but also in providing services that genuinely meet the priorities and concerns of our patients, members and the public.

Our focus this year has been not only to address the savings required (which we achieved) but more importantly to maintain a quality service for our patients which reflects our vision of "Excellence in Health, Putting People First".



As I escort visitors around the Trust without exception they have all commented on how enthusiastic and positive staff are in every ward and department they have visited and indeed the inspectors from the Care Quality Commission during their recent unannounced visit commended staff on their willingness to speak to them and to talk enthusiastically about their work here at City Hospitals. It is a delight and makes me very proud to hear and see first hand the dedication and commitment of our staff at all levels within the organisation.

For patients, their relatives and carers their time in hospital often leaves them with a sense of having lost control of their lives and of not being able to help those closest to them. We must always remember that the experience of those who use our services is really important. As I visit areas I seek from patients their views not only on how well we are doing but also what we can do to improve – there are times when we let people down or do not live up to what they expect from us and for that I apologise. We must never be complacent and must always put things right when they are wrong and learn from those mistakes.

Our Board of Governors have contributed to discussions around patient experience and I am grateful for their support, insight and enthusiasm.

It was with great sadness that one of our public governors, Ivy Lemmon sadly passed away after a short illness in December 2011.

Although she had only been with the Trust a short time all of us who knew her were touched by the care and compassion that she had for others. Ivy felt really honoured that by being a Governor she could make a real difference to patients and was desperate to become more involved but sadly her illness prevented her from doing so.

We shall all miss Ivy who was such a glamorous warm lady and whilst she felt so grateful to be working with everyone in the Trust it is us who are so grateful for having known her.

My thanks must also go to the Board of Directors who work diligently to give assurance about the safety and quality of the services we provide.

My particular thanks to Bryan Charlton who retired at the end of September having been initially appointed in 1998 as a Non Executive Director and carried on that role when we became a Foundation Trust in 2004. Bryan often when needed reminded us that it is the people of Sunderland whom we serve that is important – he knew when to become involved and more importantly he knew when to stand back and let the executives get on with their work. He was a loyal servant to the Trust and his input to our discussions surrounding patient care enabled all of us to keep a focus on our main aim – a satisfactory and good outcome for all our patients.

I was delighted to welcome Stewart Hindmarsh who joined the Trust in January this year as a new Non Executive Director and also David Barnes who joined in a 'shadow' capacity in January and will take up his substantive appointment in October 2012. We look forward to working with them in the coming months.

The year ahead will not be without its challenges – there is no doubt that CHS and the NHS face pressure and uncertainty as the new reforms are introduced against a backdrop of financial constraint.

Our challenge going forward is to tackle the financial demands on us, find smarter ways of working, develop partnerships both new and old and build on the many opportunities that will present themselves.

I do not underestimate the pressure on staff now and in the future but City Hospitals is extremely fortunate in having a workforce who consistently strive for excellence and they are well equipped to face the future. My thanks to all of them for their commitment, dedication and professionalism.

JOHN N ANDERSON QA CBE
Chairman

CHIEF EXECUTIVE'S STATEMENT 2011/12

There is no doubt in my mind that much of the year has been dominated by continued debate – both inside and outside of the NHS – about the proposed Health and Social Care Bill, which as I write this has just received Royal Assent. Aside from the natural predisposition to discuss structures and organisations, the biggest issues have almost slipped by without too much publicity. These issues are Information and Openness. Both these issues have the ability to influence how City Hospitals and our whole health system will operate in the future and one way or another will promote further aspects of both choice and competition. We will need to be prepared for that and certainly based on our performance during 11/12 we have a sound platform to build on and many opportunities to grasp.

The precise details of our performance this year are dealt with later in this report, but in summary we have had another very successful year. All key waiting times for admission, outpatients, cancer and diagnostics exceeded the targets agreed with the Commissioners for the year. The only 'failure' we have had this year was with C. difficile infections, which exceeded our target by 20 cases. Each quarter our performance has improved and if that trend continues into 12/13 then we will have a fighting chance of delivering against next year's target of 44 cases. On the upside with infections, we only had one MRSA case for the whole year, proving that our human and physical investment in this area is reaping rewards. I am also pleased to report that our A&E department at the Royal Hospital had another tough but ultimately successful year. Patient numbers attending the department have increased again and it is no longer unusual to see over 400 attendances in one day, many brought in by a record number of ambulances. I am particularly pleased with the efforts put in by the whole A&E team to see us though the 4th quarter – some around us doubted it could be done, but they have been proved well and truly wrong. I am also delighted that the Board have now accepted the case for a brand new A&E department and we will be seeking external funding to finance this (not PFI!) – hopefully we will see this started early in 13/14 but given the 24/7 nature of service in A&E it may take us some time to complete!

The financial position of the organisation has also improved in 2011/12. The Trust has delivered a £3.78m surplus for the year, some £1.78m above our plan for the year. Cash remains healthy with no need in the year to use the Trust's working capital facility. This position reflects tight cost control by departments, significant over performance on contract paid for by commissioners and a much more positive trading position generally across the board. The required external efficiency targets set for the year were also achieved. Given that this is also the first year of the NHS's three year drive to deliver £20bn worth of efficiencies, then this performance is all the better.

However life at City Hospitals is not all about performance and money. There are many other examples of where we are getting better and improving services to patients. We finally opened our new ward block with four new wards and our Stroke Service, Renal Service, Orthopaedic Service and Integrated Critical Care Unit are now providing an even better service than before in fantastic new accommodation. Feedback from patients has been excellent and the opportunities I have had to visit are always positive ones. Car parking too has improved – not only do we have more spaces but we are improving access for patients and visitors, which they are acknowledging in clinics every day. We also introduced 'Parking Eye' this year to give us better control over our car parks and after some teething problems at the start – and my apologies go particularly to Blue Badge holders – we are now seeing and feeling the benefit of this. I should take this opportunity of reminding everybody that it is just Parking Eye Technology that we are using – control of everything else, including charges, remains the Trust's responsibility. Our new multi storey car park will start on site during 12/13 and help again with access problems in the future.

Quality of care is, and will remain, the Trust's number one priority. Evidence from the staff survey would indicate that an element of our staff did not believe this to be true, so we will be working harder next year to make sure staff do understand that this really is the case. During the course of this year the Trust was involved in three unannounced visits by the Care Quality Commission (CQC). The first, in October 2011, looked at quality, privacy and dignity of care and after an intensive two day visit the CQC confirmed that we were compliant with appropriate standards, and commented how impressed they were with staff who were queuing up to tell them about new and best practice. The second visit was a joint one with the Local Authority on Safeguarding – and again I am pleased to write that the health element of this was assessed as good. The last was a visit, in line with most other Trusts, to look at our arrangements for dealing with termination of pregnancy and despite no concerns about safety and care for patients some aspects of our documentation will need to be tightened up with immediate effect. When we receive these sort of reports - and in line with those we receive from the Coroner (Rule '43s') – we immediately try to learn lessons, communicate that back to the organisation and improve going forward. Overall mortality in CHS is 'as expected' for our type of hospital and its services, but in recent months we have seen a marked improvement in this as well, and the Board wish to see this trend continue.

It is however staff that make the ultimate difference and yet again I would like to pay tribute too all 5,000 or so of you, who have risen to the challenges so well during the year. Your professionalism, dedication and loyalty is evident for all to see. Our Staff Reward and Recognition event gets bigger every year and this year's was no exception with many staff receiving well deserved long service awards as well as specific recognition for others. I was particularly pleased to be able to present the Dining Room Servery staff with my personal award this year and was absolutely "gobsmacked" by their reaction on receiving their award – very well done!

> No matter what the quality of buildings or technology, it is the staff who provide the service that makes the difference

As usual we have seen some staff leave us and new ones arrive this year. I will pick out three here. Firstly Bryan Charlton, one of our original Non-Executive Directors stood down from his role at our AGM in September and I would like to take this opportunity to publicly thank him for all his contributions over 14 years and to wish him well for the future. Secondly Ivy Lemmon, one of our Governors, sadly passed away in December 2011 after fighting her illness with much courage for some time. She is, and will be, sadly missed by all who knew her and was a fantastic lady. Thirdly in July, we were pleased to welcome Joy Akehurst to the Board as our new Director of Nursing and Quality – one of the most important roles in the organisation, and she has a difficult job to follow in the footsteps of Carol Scholes, who retired in March 2011.

There are many, many others that I should thank in this report but space prevents me. My Chairman, John Anderson, has again supported me and City Hospitals superbly during the year and it was great news that he has been reappointed by the Governors for another three year term as Chairman. The other Non Executive and Executive Directors also continue to expertly oversee the work of City Hospitals, and ensure we deliver what we say we will deliver, with appropriate challenge and assurance. My thanks go to them all. My last thanks go to Carol Harries who does so much for City Hospitals and our patients – she really is a great ambassador for the organisation internally and externally. Looking ahead, there is much to look forward to. We are in the process of implementing a brand new version of our Meditech Information System and we will also seek to radically improve our communications with patients as part of that – having good information, as I mentioned at the start, is the cornerstone of a successful organisation. More important than even that is the time I now need to spend securing our strategic direction – and as part of our Bigger Picture Work with South Tyneside and Gateshead we will try and identify the future pattern of hospital and other care looking ahead at least five years to ensure we have safe, high quality and sustainable services and organisations fit for the future. We have started on that work formally in 11/12 and, subject to public consultation, all acute inpatient paediatrics will be centralised for South of Tyne at City Hospitals (although the choice of others still exists) and fast on the heels of this will be plans to develop one centre of excellence for 'cold' pathology across South of Tyne, backed up by 'hot' facilities on each site. Other services will follow and key amongst them for City Hospitals will be Trauma, Neonatology, Maternity and Vascular Surgery. Without these changes even a big organisation like City Hospitals will struggle to deliver the right quality with the right staff in the medium to long term – so preparing for that now gives us the best chance of success.

As I write this report I have just said goodbye to HRH The Duke of Kent, who has been here opening our new ward block – to be known as the Jubilee Wing – and his closing remarks said it all – no matter what the quality of buildings or technology, it is the staff who provide the service that makes the difference.

KEN BREMNER
Cheif Executive

OFR: Operational Reporting

A brief profile of the organisation:

City Hospitals Sunderland was established as an NHS Trust in April 1994 and under the Health and Social Care (Community Health and Standards) Act 2003 became an NHS Foundation Trust in July 2004.

The Trust provides a wide range of hospital services to a local community of around 350,000 residents along with an increasing range of more specialised services provided to patients outside this area, in some cases to a population as great as 860,000.

The Trust also provides a substantial range of community based services, particularly within Family Care and Therapy Services.

The Trust operates from:

- Sunderland Royal Hospital (owned by the Trust)
- Sunderland Eye Infirmary (owned by the Trust)
- The Children's Centre, Durham Road (owned by the Trust)
- Monkwearmouth Hospital (on a limited basis)
- Church View Medical Practice

and provides outreach services at:

- Washington Galleries Health Centre
- Grindon Lane Primary Care Centre
- Bunny Hill Primary Care Centre
- Washington Primary Care Centre
- Hartlepool General Hospital
- South Tyneside General Hospital
- Queen Elizabeth Hospital, Gateshead
- Bishop Auckland General Hospital
- University Hospital of North Durham
- Shotley Bridge Hospital

The Trust has around 894 acute beds, an annual income of around £306.02m and fixed assets of £205.37m. It employs around 4,973 people.

Staff Group	FTE	Headcount	%
Professional Scientific and Technical	153.54	177	3.56
Additional Clinical Services	774.96	891	17.92
Administrative and Clerical	896.32	1,046	21.03
Allied Health Professionals	257.84	300	6.03
Estates and Ancillary	343.29	415	8.35
Healthcare Scientists	98.93	106	2.13
Medical and Dental	394.73	423	8.51
Nursing and Midwifery Registered	1,461.51	1,608	32.33
Students	7.00	7	0.14
Staff Group Summary Total	**4,388.12**	**4973**	**100%**

Employed as at 31 March 2012

The Trust is organised into six main divisions and departments of Trust Headquarters. Within the six main divisions are a series of clinical directorates and departments.

Division of Clinical Support

- Therapy Services (including Physiotherapy, Occupational Therapy, Speech and Language Therapy, Podiatry, Dietetics and Medical Photography)
- Pharmacy
- Radiology
- Medical Physics
- Pathology

Division of Family Care

- Obstetrics and Gynaecology (including Genito Urinary Medicine)
- Paediatrics and Child Health

Division of Medicine

- Emergency Medicine (including Emergency Department, Cardiology and Acute Medical Unit)
- General Internal Medicine (including Gastroenterology, Metabolic Medicine and Thoracic Medicine
- Medical Specialties (including Renal Medicine, Clinical Haematology and Rheumatology)
- Rehabilitation and Elderly Medicine (including Care of the Elderly, Neurology, Neuro-Rehabilitation and Neurophysiology)

Division of Surgery

- General Surgery
- Urology
- Head and Neck Surgery (including Ear, Nose and Throat, Oral and Maxillo Facial Surgery and Orthodontics)
- Ophthalmology
- Trauma and Orthopaedics
- Theatres (including Integrated Critical CareUunit, Anaesthetics and Day Case Unit and Theatre Sterile Supplies)

Division of Estates and Facilities

- Catering
- Domestics
- Estates
- Laundry and Linen
- Outpatients
- Portering and Security
- Transport

Department of Trust Headquarters

- Chairman and Chief Executive
- Clinical Governance
- Corporate Affairs
- Finance
- Human Resources
- Information Services
- Information Technology & Information Governance
- Medical Director
- Nursing and Quality
- Performance
- Strategy and Service Development

Staff Consultation and Involvement

We know that it is important for staff to be informed and involved with developments at the Trust.

We have a trade union recognition agreement with a range of organisations including the Royal College of Nursing, the British Medical Association, Unison and Unite, and effective arrangements for consultation and negotiation with staff side representatives, through regular Joint Consultative Group (JCG) meetings. During the year the JCG has been involved in regular discussion and agreement surrounding key HR policies.

Other examples of how we communicate and consult with our staff are set out below:

- the publication of 'Good4U', an employee Health and Wellbeing newsletter;
- a regular Chief Executive's bulletin;
- the weekly 'Grapevine' bulletin is published on CHS net, the Trust's intranet;
- well-established intranet and internet site giving information on key strategic issues and directorate/departmental news;
- a formal Team Brief system following Executive Team meetings to cascade key strategic messages across the Trust and more importantly to encourage feedback; and
- the Chief Executive holds a number of regular forums with Clinical Directors, senior managers, Consultants, key nursing staff and allied health professionals.

Monitoring and Managing Performance

To support performance improvement, a robust monitoring and reporting system is in place:

- monthly reporting of financial performance to the Executive Committee and Board of Directors measured against areas such as:
  - income and expenditure performance
  - cost improvement programme
  - monitor risk rating metrics
  - balance sheet and working capital
  - cash and liquidity
- monthly reporting of cost improvement plan delivery by directorate to the Finance Committee, a formal sub committee of the Board of Directors;
- monthly reporting of activity, waiting list and key performance indicators;
- root cause analysis meetings with the Chief Executive and Medical Director to understand in detail the reasons for Healthcare Acquired Infections and Serious Untoward Incidents;
- detailed monthly reports for Divisional General Managers, Directorate Managers and Clinical Directors;
- monthly meetings with Directorate Managers and representatives from Finance and Performance to identify trends and areas of concern in time to plan ahead and agree action plans; and
- involvement in performance forums external to the Trust to consider shared issues.

The following pages outline the activities undertaken within the Trust relating to Non-Financial Performance.

Details of Financial Performance may be found on page 118 in the Operating and Financial Review.

> We aim for excellence in everything we do - our first priority is our patients

Key Aims and Objectives

The ethos of the Trust is based on:

"Excellence in Health, Putting People First".

The Trust aspires to be a provider of first class NHS services and to be the first choice of patients locally, regionally and in some cases nationally. We will maintain our high quality services and be focused on, and responsive to, the requirements and expectations of our customers.

To support quality we will ensure that our workforce is the best in the healthcare industry. Our staff will have the freedom to act to meet our commitments to high quality and responsiveness, to innovate and to ensure that the patient is put first. Staff will be accountable for their actions and will have the confidence and the support of the organisation for what they do.

The Trust will deliver its vision and aspirations by adhering to the following values:

- ensuring our care is high quality, safe and personal;
- enabling our staff to use their skills to treat patients in clean, comfortable surroundings to the highest quality, offering choice as widely as possible;
- encouraging our patients to come here for their care because we aim for excellence in everything we do – our first priority is our patients; and
- setting high standards of behaviour and professionalism for all our staff.

The Board will continue to drive the Trust's vision and philosophy through a number of key delivery areas:

- **Best Quality**
  - we will listen to our patients;
  - we will respect and care for you in a dignified way;
  - we will improve your health and quality of life; and
  - we will measure whether you would be happy with the standard of care provided by this Trust if a relative or friend needed treatment.
- **Highest Safety**
  - we will strive to have no patient errors or failures; and
  - we will properly train staff in sufficient numbers.
- **Shortest Lead Time**
  - we will treat you as quickly as possible and not waste your time; and
  - we will minimise any delays.
- **Highest Morale**
  - we will make you proud to work here; and
  - we will develop and support you and your teams to be the best at what you do.
- **Cost Leadership**
  - we will generate a surplus to reinvest in your care; and
  - we will save money on things you don't need so that we can improve the things you do need.

Future Developments

There are a number of key priorities for the Trust to deliver. These are to:

- align organisational resources to deliver the vision;
- introduce and embed lean training and techniques throughout the organisation to deliver continuous improvements in quality;
- create and sustain a proactive "can do" culture where staff are empowered;
- encourage and foster innovation;
- have zero tolerance for waste;
- use quality improvement to deliver cost effectiveness;
- allocate resources to deliver organisational priorities;
- compete against tariff to deliver tariff minus 10%;
- deliver a significant surplus to reinvest in healthcare services; and
- benchmark nationally against the top 10% performers for key quality, performance and financial measures.

The Trust is also committed to ensuring that our environment is of a high quality in which patients can receive treatment and staff can work. This has led to the completion of the following schemes during 2011/12:

- the conversion of ward B25 into a dedicated Urology Treatment Centre providing both outpatient and daycase facilities;
- the provision of a Silver Command control room ensuring the Trust has robust facilities available in the event of an emergency or major incident;
- the installation of automated laboratory machines within the Pathology department to streamline and decrease the turnaround time of patient testing;
- the replacement of the hospital bleep system ensuring over 1400 key staff are easily contactable; and
- the conversion of ward E55 into a dedicated Discharge lounge enabling patients to wait in more comfortable surroundings as they prepare to go home.

Work has also commenced on the following:

- the conversion of ward D45 (the old Integrated Critical Care Unit) into a new Chemotherapy Treatment unit;
- the provision of a multi-storey car park giving much needed additional parking spaces on the current Kayll Road car park;
- provision of a centralised Pre-Admission Assessment clinic;
- the upgrade of all disabled and public toilets;
- provision of a dedicated Bariatric outpatient unit for a rapidly developing service;
- the commencement of an outreach facility within the City of Durham to support our specialist sub-regional services;
- the provision of a dedicated Breast Surgical Assessment Unit; and
- the detailed planning for a new Emergency department.

Strategic Priorities

The top five strategic priorities for the Trust are:

- **Best Quality**
  - improving communication with patients, between staff and with external stakeholders
  - improving the clinical and physical environment
  - monitoring and responding to patient issues and learning from feedback
  - rapid process improvement workshops to improve key performance issues
  - improving the patient experience in areas such as pain management and nutrition.
- **Highest Safety**
  - eliminating never events and improving our response to incidents and any associated learning
  - improving control of infection effectiveness
  - improving standardised mortality and complication rates
  - delivering harm free care reducing the number of pressure ulcers, falls and catheter acquired infections
- **Shortest Lead Time**
  - world class diagnostics and separation of elective and emergency streams
  - shorter pathways, fewer steps, faster diagnosis and most effective treatments
  - reduced length of stay and moving to ambulatory care pathways wherever appropriate
  - introducing more effective electronic patient records and care plans
- **Highest morale**
  - improving the internal planning process to involve more staff
  - improved openness and transparency in decision making
  - improving staff engagement
- **Cost Leadership**
  - supporting financial viability by removing waste
  - clinically effective pathways avoiding admission and readmissions, or reducing length of stay whenever appropriate

Future Performance

The Trust's future performance is based on a number of factors:

- financial viability and sustainability;
- our capacity to manage demand;
- our ability to deliver high quality performance;
- our skill in competing with other healthcare providers; and
- the appropriate recruitment and skills level in our staff.

For 2012/13 our key concern will be the delivery of our vision against a backdrop of a continuing difficult economic outlook, increased competition and the transition to the new health and social care system. As clinical commissioning develops service provision will be transformed. The Sunderland Clinical Commissioning Group(CCG) has developed a "clear and credible" plan for 2012-2017 which describes their vision of achieving "better health for Sunderland" supported by three high level goals:

- to improve the health and wellbeing of all local people; enabling them to live longer, with a better quality of life and to reduce health inequalities across the locality;
- to improve the integration of services across Health and Social care; and
- to underpin all developments with more effective clinical decision making.

The plan does not as yet contain any interventions or deliverables. A continuing area of concern however, is the introduction of demand management initiatives which may result in a failure by CCGs to deliver a reduction in activity at the Trust and may also impact on our ability to reduce costs to match any loss of income.

A key issue going forward will be for us to continue to develop close working relationships with CCGs in order to understand the proposed direction of travel and the potential impact of any changes to service delivery.

At a time of unprecedented financial pressures across the NHS, the Foundation Trusts and Commissioners across South of Tyne have agreed that in the future having three primarily acute hospitals is no longer viable.

For City Hospitals our focus will be on becoming the third specialist centre (or main hub) across the North East and to increasingly concentrate on more complex/specialised services, both elective and non elective. More complex colorectal, vascular and stroke services will start the development of a cardiovascular, renal and metabolic service to work alongside primary care. Our focus as a Trauma Unit will be supplemented by a world class critical care unit and our ability to offer complex diagnostics.

Local access to emergency medical services will be enhanced by a brand new Emergency Department and admission pathway(s).

The Trust will continue to enhance and expand its Medical Education reputation through its role as the hub for the Wear based educational unit.

Doing nothing is no longer an option – more and more quality standards are being introduced and guidance highlights many aspects of healthcare and their relationship to a critical mass of population.

Year End Position

City Hospitals has reported a surplus position of £3.78m for the financial year 2011/12. The Trust delivered cost improvements of £17.9m during the year and delivery of Cost Improvement targets were closely monitored in year by the Finance Committee, a Board sub-committee.

For 2011/12, the Trust signed legally binding contracts for its services provided to commissioners. These related to Payment by Results (PbR) activity and services subject to local prices where national tariffs had not been set.

The Trust's largest commissioners had set 2011/12 contract baselines predominantly based on the 2010/11 actual activity delivered with funding specifically relating to the maintenance of all of the relevant targets. In activity terms, the overall elective contract over-performed against this baseline by 12.2% whilst the non-elective contract over performed by 7.1% with income and expenditure consequences across the whole organisation but particularly in surgical specialties.

Service Line Reporting

During 2011/12 Directorates received additional supporting information at an overall service line. This included an assessment at service line level of the profit and loss position. On a quarterly basis this information was discussed at the Finance Committee as one of the financial metrics that gave an assessment of the overarching health of a Division.

The full roll-out of the automated patient level costing system occurred during 2011/12. Clinical leaders are engaged in the validation process. In the latter part of the financial year the information was being used to support the developing Trust wide strategy. This will be further enhanced during 2012/13 to support decision making for service developments.

Regulatory Rating Performance

The Trust is required to submit performance information to the Foundation Trust regulatory body 'Monitor' on a quarterly basis. At the start of each financial year, the Trust is required to submit an annual plan identifying the expected performance against financial targets and a range of national targets set by the Department of Health and other regulatory bodies. The financial performance is assessed over a range of metrics including liquidity and in year income and expenditure performance. For financial risk assessment, the rating scale is a sliding scale from 1 (poor performance) to 5 (good performance). For governance and quality risk the scale is a traffic light system with ranges from red (poor) to green (good).

The Trust submits actual performance information compared to the plan and Monitor assesses this performance in order to determine an overall rating for the Trust at the end of each quarter. The planned versus actual performance for the 2011/12 and the 2010/11 financial years is detailed in the tables below.

	2011/12				
	Annual Plan	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Amber Red	Amber Red	Amber Green	Amber Green	Amber Green

	2010/11				
	Annual Plan	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Financial Risk Rating	3	4	3	3	3
Governance Risk Rating	Amber Green	Green Green	Green	Green	Green

The Trust is required to submit performance information to In relation to Governance for 2011/12, the Trust declared itself 'Amber-Red' in the annual plan, due to concerns over delivery of two targets being the A&E four hour wait and the very challenging C. difficile targets. This was reflected in the Quarter 1 performance, but, since then the Trust has achieved the A&E target from Quarter 2 onwards. Unfortunately the Trust failed the C. difficile target for each quarter. The overall risk rating from quarter 2 onwards was therefore an 'Amber-Green' rating. In terms of financial reporting, the Trust had planned to deliver an overall surplus of £2m, giving an overall risk rating of 3. The Trust achieved at least a rating of 3 each quarter, ending the year in line with plan, with a surplus of £3.78m.

Risk Management

Financial Risks

Key financial risks during 2011/12 included:

- maintaining compliance in both the maternity and general risk standards and preparing for improvements;
- delivering the challenging Cost Improvement Target on top of maintaining the achievements from prior years;
- taking account of a new version of the National Tariff which resulted in a requirement to deliver an efficiency target of 4%;
- delivering against the quality (CQUIN) targets as agreed with the PCT;
- the delivery of significant additional activity within existing staffing and physical capacity resources; and
- delivery of the new ward block scheme to time and within the remit of the original business case.

Non-financial Risks

Non-financial risks for the year included:

- achieving and maintaining the relevant standards including the 18-week target for 95% of admitted patients in year across all specialties and the maximum 4 hour wait for A&E patients;
- achieving control of infection targets including MRSA target of 6 cases for the full year and the C. difficile target of no more than 44 cases for the full year; and
- maintaining the standards required by the Care Quality Commission to maintain compliance with registration requirements.

Directors' Approach to Risk Management

Directors' Approach to Risk Management includes:

- a Cost Improvement Plan to reduce the Trust's operating costs during 2011/12 to meet the efficiency target inherent in the national tariffs;
- the roll-out of Service Line Reporting focusing effort into those areas that will have the greatest financial impact;
- working with Commissioners to plan service redesign and service capacity requirements including identifying all implications financial and non-financial; and
- managing the levels of actual activity and the costs associated in specialties with capacity constraints.

During 2011/12 the Board of Directors reviewed and revised the Risk Management Strategy with the objective of ensuring:

- identification of principal risks to the achievement of the Trust's objectives;
- evaluation of the nature and extent of the risks; and
- efficient, economical and effective management.

The National Health Service Litigation Authority (NHSLA) has in place schemes to encourage and support Trusts in effectively managing risks and claims. One of the key milestones in the Trust's Risk Management Strategy is to achieve progressive compliance with national, general and maternity NHSLA risk management standards. During 2011/12 the Trust has been planning for the next assessment for NHSLA general standards.

The Board of Directors has approved an assurance framework that meets national guidance which is managed by the Governance Committee. The framework is subject to annual review and approval by the Board of Directors. The framework is based on the Trust's strategic objectives and contains an analysis of the principal risks to achieving those objectives. It is underpinned by the detailed risks and associated actions set out in the Trust's risk register. During 2011/12, the Trust further developed the Assurance Framework and the overall Risk Register and the on-going developments will be fed to the Board of Directors during 2012/13.

Each of the key objectives has been assigned a Board lead and the framework is utilised to ensure that the necessary planning and risk management processes are in place to deliver the annual plan and provide assurance that all key risks to compliance with authorisation have been appropriately identified and addressed.

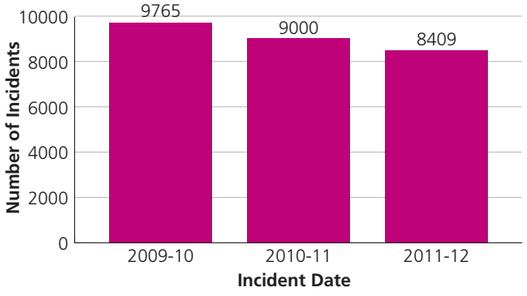
Incident Reporting

The Trust's Risk Management Strategy governs the reporting, analysis and investigation of all strategic, managerial, operational and financial risks within the organisation. It demonstrates the Trust's continued commitment to delivering improved patient, staff and public safety through performance-driven risk management, underpinned by an open, learning culture. The Risk Management Strategy is reviewed annually. All serious incidents are reviewed at director level with actions and learning taken through our newly established Red Incident Review Group. A programme of 'Lessons Learned' sessions has been delivered over 2011/12. These have been well attended by a wide range of professional and other staff and include learning from both Coroner's inquests and serious incidents.

Incidents

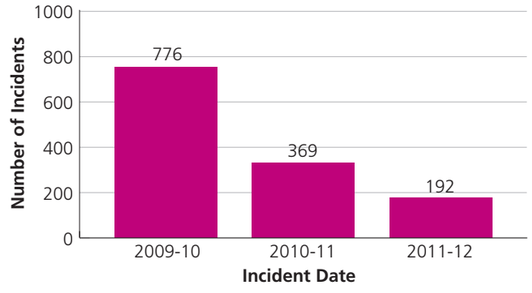
During 2011/12 a total of 8409 incidents involving City Hospitals Sunderland were logged on the Trust incident database, a decrease from the previous year of 3.2%. We encourage staff to report incidents and 'near misses' so that we can learn and ensure that there is ongoing quality improvement. Staff also report incidents in which there may have been partner organisation involvement e.g. other hospitals, ambulance services, nursing and care homes and again, this enables us to work together with partners to improve health services in Sunderland. Work to reduce the number of falls and pathology related incidents has had a significant effect during the last year with falls reducing by 3% and pathology related incidents by 52%.

Reported Incidents



Incidents Related to Falls

Incidents Related to Diagnostics – Pathology

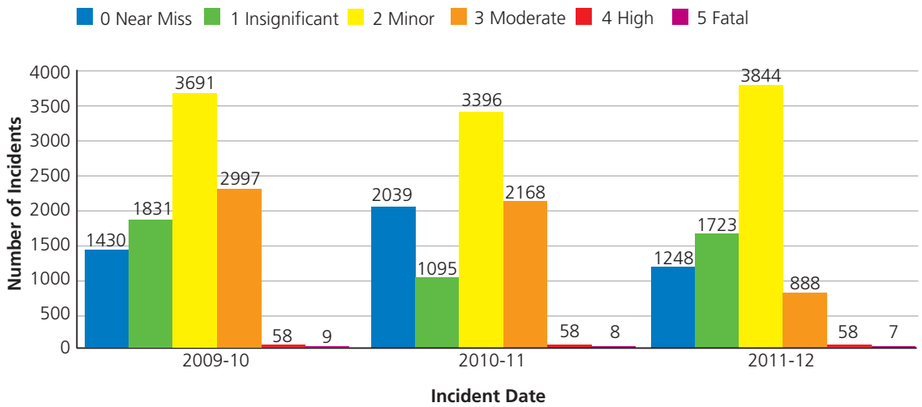


All incidents are given an 'impact' grading. An indication of an improving safety culture is demonstrated when 'near miss' reporting increases. A near miss incident is when staff can see a 'potential' safety issue for a patient, take corrective action and report the potential for an incident as a near miss.

There has however, been a decrease in the number of near misses reported largely due to:

- a decrease in pathology related incidents, the majority of which by their nature are near misses, as the checks and balances set out within the laboratory systems identified the problem prior to any harm being caused.
- A change in reporting practice which now requires staff to grade all patients reported as being "found on the floor without injury" as a level 1 (insignificant) incident rather than a near miss as had been previous practice.

The graph below demonstrates a significant increase of 9.2% in the number of reported low impact incidents during 2011/12 when compared to 2010/11 and a 13.6% decrease in moderate impact incidents which is recognised to be indicative of a strong safety culture within an organisation.



Service Improvements

During 2011/2012 a wide range of improvements have been implemented as a result of lessons learned via the incident reporting procedure.

These include:

- **The reduction in the number of patient falls –** Following an increase in falls occurring as a result of confused patients attempting to walk independently to the toilet, hourly comfort checks have been introduced for all patients who are assessed as having additional needs, such as if they are confused, have poor mobility etc. These checks involve assessing pain, warmth, nutrition and hydration, toilet needs or any other specific needs. The assessment also includes a physical check to determine any incontinence issues which would be immediately addressed. In addition all patients being nursed in bed have positional changes carried out at regular intervals based on their level of dependency, ranging from 1 hourly to 4 hourly to minimise the prevalence of pressure sores.
- **Pressure ulcers are a major cause of pain and discomfort –** Patients are often admitted from their own homes or care homes with pressure ulcers caused by poor health and mobility. All 'serious' pressure ulcers which are identified when a patient is admitted or develop during admission are now reported as an incident. This enables us to review the causes and to ensure actions are taken to prevent further occurrences where possible. A rolling programme of educational sessions has been developed and implemented and this has been reinforced by a half day symposium aimed at raising awareness and promoting good practice. All wards have a 'link' nurse to ensure that patients receive prompt assessment of skin integrity on admission to prevent deterioration or to identify existing skin damage.
- **Empowering staff –** It is important that all levels of staff feel empowered and have the confidence to act in the patient's best interest and when they feel it necessary to question decisions. Work is continuing across the Trust to reinforce the message with all staff groups that they are accountable for ensuring that their concerns are not only clearly communicated, but also that they have been acted upon. In 2011/12 we have continued our focus on ensuring that the system of Early Warning Scores concentrates on any deterioration in a patient's condition at the earliest opportunity. Staff receive this training as part of their local induction and on an ongoing basis. Completion of the Early Warning Score system is audited on a monthly basis to ensure areas are achieving 100% compliance and any shortfalls are acted upon immediately.
- **Spinal injury –** In order to provide the best possible care for patients with spinal injury, a dedicated multi-disciplinary pathway has been developed which ensures that this group of patients receives timely care direct from the appropriate specialist team who are best placed to manage the complexities of care required whilst minimising any potential delays in treatment.
- **High Impact Safety Bulletins –** The Trust recognises the importance of learning lessons following serious incidents and has introduced a communication mechanism of High Impact Safety Bulletins. This ensures that lessons learned are quickly and effectively communicated to all relevant staff in order to minimise the risk of re-occurrence. Examples of issues covered in recent bulletins are:
  - catheterisation; and
  - acting upon abnormal pathology results.

Information Governance

Whilst a key focus of Information Governance is the use of information about service users, it applies to information and information processing in its broadest sense, and underpins both clinical and corporate governance. The four fundamental aims are:

- to support the provision of high quality care by promoting the effective and appropriate use of information;
- to encourage responsible staff to work closely together, preventing duplication of effort and enabling more efficient use of resources;
- to develop support arrangements and provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards; and
- to enable organisations to understand their own performance and manage improvement in a systematic and effective way.

The Information Governance toolkit is a performance tool produced by the Department of Health (DH) which draws together the legal rules and central guidance, and presents them in one place as a set of Information Governance requirements. The Trust is required to carry out a self-assessment of its compliance against each of the 44 Information Governance requirements (Scoring 0, 1, 2 or 3).

To be classed as 'Satisfactory – Green' an NHS organisation is required to be level 2 or above across all 44 requirements. The Trust achieved this rating, the results confirming 22 standards at Level 2 and 22 standards at Level 3.

The total percentage compliance for the 2011/12 submission was 83% (3% greater than 2010/11).

The Trust can confirm that it has systems and processes in place to ensure that information risks are reliably identified, prioritised and managed.

There were no Information Governance breaches during 2011/12.

Key Constraints on Trust Activities

Neither Monitor, the Care Quality Commission, nor any other regulatory body has placed any restrictions on the activities of the Trust.

Role of the Trust as a Local Employer

Our Staff

We aim to be a responsible and supportive employer in how we manage our organisation, look after our dedicated and skilled staff and encourage local residents to find work within the Trust. We recognise that our employees play a vital role in our progress towards our Vision of "Excellence in Health, Putting People First", by becoming the best acute hospital. Our employees have a direct impact on our clinical outcomes and we are clear that when our employees are well and satisfied, the experience of our patients improves.

Whilst the range of programmes available under the current government have changed the Trust has continued its work to help disadvantaged groups into work, particularly those who are unemployed, young people and individuals with a learning disability.

The Trust recruited four unemployed people on the City of Sunderland's "Creating Jobs in the Real Economy" programme and offered them six month training opportunities as trainee Healthcare Assistants. Two of the four individuals subsequently secured permanent full time posts as Healthcare Assistants within the Trust.

A further twenty nine local unemployed individuals undertook work experience within the Trust as part of the Government's work programme offering short-term work experience. Nine of the twenty nine were successful in being appointed to vacancies in the Trust with a further three trainees securing employment elsewhere on leaving the Trust.

The Trust has also worked with Springboard Sunderland Trust to host apprenticeships in Administration and Care roles for young people in the city. During the year twenty apprentices commenced with the first successfully moving into a full time vacancy as a Healthcare Assistant.

The Trust was also successful in winning two awards at the annual regional Springboard Trust event, where both trainees and employees across Sunderland, East Durham, Hartlepool and South Tyneside were nominated for awards. Sophie Roberts won "Apprentice of the Year" and the Trust won "Employer of the Year" for the calibre of the training offered to apprentices.

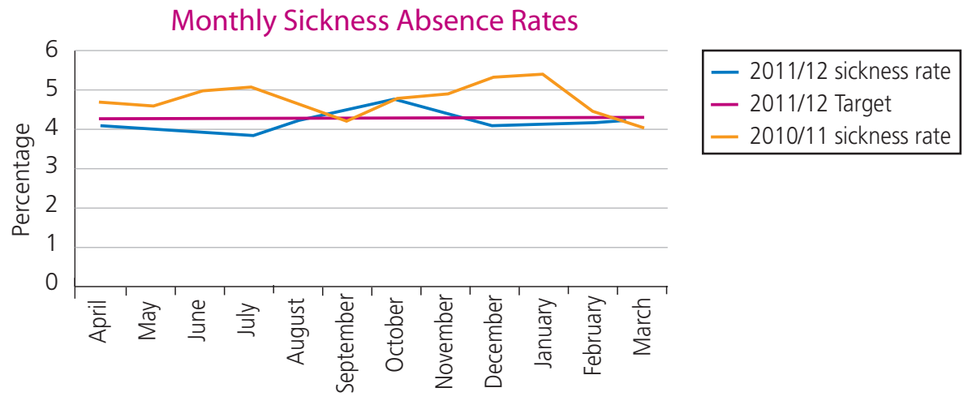
Our internship programme for students with learning disabilities has continued to develop and a further ten students are gaining supervised work-based experience with the Trust. Four of the participants from the first cohort moved into apprenticeships with the Trust on completion of their programme with one student successfully moving into permanent employment in our Pathology Department.

Marie Hall and George Gill, members of our Portering and Security Team.

Employee Health and Wellbeing

The Trust takes seriously its responsibility to manage employee absence appropriately – working closely with staff side representatives both individually and collectively through our joint Consultative Group on developing policies and procedures which reflect best practice, comply with national guidance, legislative requirements and terms and conditions of service.

Our Occupational Health department also plays a key role in supporting staff and managers through the Trust's attendance policy. The Trust's sickness absence rate for 2011/12 was 4.09% against a target of 4.30%. The graph below shows year to date sickness absence rates for the 2011/12 year.



This year has also seen the development of our Employee Health and Wellbeing Strategy, which supports the Trust's overarching Human Resources Strategy, detailing our commitment to become the best place to work. It acknowledges that work and the health and wellbeing of our employees are interlinked and that the Trust is committed to promoting a culture of wellbeing. As part of the strategy the Trust offers a range of employee health and wellbeing benefits which include:

- Provision of an Employee Assistance Programme – a confidential support service provided by First Assist;
- A dedicated Occupational Health department offering health surveillance and access to fast track physiotherapy;
- An Employee Benefits Day;
- An on site Health and Fitness Centre;
- Free eye screening and testing;
- The opportunity to access the Cyclescheme and Family Car scheme;
- Provision of Childcare vouchers; and
- An annual Reward and Recognition event recognising long service and celebrating the many and varied contributions our staff make to patient care.

Future plans include an overarching health and wellbeing improvement framework which will be developed to meet the needs of our staff.

Staff Survey Results

The Trust participates in the NHS Annual Staff Survey conducted by the Care Quality Commission which seeks the views of staff on a wide range of issues. The results of the 2011 survey were published in March 2012 and overall, the report shows similar results to those from 2010. This year however, our response rate rose from 39% of staff responding to 56% which was higher than the national response rate of 54%.

The key findings from the survey are summarised below:

2009/10 Response Rate		2010/11 Response Rate		2011/12 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	Trust	National Average	Trust
45%	55%	39%	54%	56%	54%	17%

Top 4 Ranking Scores

Perceptions of effective action from employers towards violence and harassment:
(the higher the score the better)

Staff were asked questions about the extent to which they think their Trust takes effective action if staff are physically attacked, bullied, harassed or abused. Possible scores range from 1 to 5, with 1 representing the perception that the Trust does not take effective action, and 5 representing the perception that the Trust does take effective action.

The Trust's score of 3.75 was in the highest (best) 20% when compared with Trusts of a similar type.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
37.5	3.56	3.75	3.58	No change

Percentage of staff working extra hours:
(the lower the score the better)

Staff were asked whether in an average week they worked longer hours than the hours for which they were contracted. The Trust's score of 55% was in the lowest (best) 20% when compared with Trusts of a similar type, although a slight deterioration from last year.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
53%	66%	55%	65%	-2%

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months:
(the lower the score the better)

Staff were asked whether they had experienced harassment, bullying or abuse from colleagues or managers in the previous twelve months. The Trust's score of 12% was in the lowest (best) 20% when compared with Trusts of a similar type, although a slight deterioration from last year.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement/Deterioration
Trust	National Average	Trust	National Average	
11%	15%	12%	16%	1%

Percentage of staff using flexible working options:
(the higher the score the better)

Staff were asked whether they were given any opportunities for flexible working options such as working flexi-time, reduced hours, from home or job sharing etc. The Trust's score of 67% was in the highest (best) 20% when compared with Trusts of a similar type.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement/Deterioration
Trust	National Average	Trust	National Average	
66%	63%	67%	61%	1%

Bottom 4 ranking scores

Percentage of staff reporting errors, near misses or incidents witnessed in the last month.
(the higher the score the better)

The Trust's score of 93% was in the lowest (worst) 20% when compared with Trusts of a similar type.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement/Deterioration
Trust	National Average	Trust	National Average	
99%	95%	93%	96%	6%

Percentage of staff having equality and diversity training in the last 12 months.
(the higher the score the better)

The Trust's score of 32% was in the lowest (worst) 20% when compared with Trusts of a similar type.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement/Deterioration
Trust	National Average	Trust	National Average	
34%	41%	32%	48%	2%

Percentage of staff being appraised in the last 12 months:
(the higher the score the better)

Staff were asked whether they had received an appraisal, performance development review or annual development review in the last 12 months.

The Trust's score of 70% was in the lowest (worst) 20% when compared with Trusts of a similar type, although an increase from the previous year.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement/Deterioration
Trust	National Average	Trust	National Average	
66%	78%	70%	81%	4%

Staff motivation at work:
(the higher the score the better)

Staff were asked about the extent to which they looked forward to going to work, and were enthusiastic about, and absorbed in their jobs.

The Trust's score of 3.73 was in the lowest (worst) 20% when compared with Trusts of a similar type.

2010/11 Response Rate		2011/12 Response Rate		Trust Improvement/Deterioration
Trust	National Average	Trust	National Average	
37.4	3.83	3.73	3.82%	0.01

Largest local change since the 2010 survey

The largest local change since the 2010 survey was the percentage of staff reporting errors, near misses or incidents they had witnessed in the last month, which was 93% compared to 96% nationally and a 6% reduction from our score of 99% in 2010.

Overall there is little change between our survey scores in 2010 and those of 2011. Effective staff engagement however, depends on the extent to which our staff feel the Trust values their work, which in itself is achieved through a number of different actions.

Following discussions within the organisation, key areas have been identified for attention during 2012/13:

- having an appraisal and personal development plan;
- reporting errors, near misses or incidents;
- being able to contribute towards improvements at work;
- recommending the Trust as a place to work or receive treatment; and
- having equality and diversity training.

The resulting action plan has been referenced to the four pledges to staff contained within the NHS Constitution.

The following actions will be a key focus during 2012/13:

- All line managers ensuring that staff:
  - have an annual appraisal;
  - get feedback on their performance;
  - receive their monthly Team Brief; and
  - are being involved in decision-making
- Reviewing the Appraisal Policy including an option to remove a pay increment for those at the top of a pay band, where there is evidence of failure to carry out/participate in an annual appraisal.
- Undertaking a further audit of appraisals and personal development plans;
- Raising staff awareness of how to report errors, near misses or incidents;
- Ensuring that staff are involved with service improvement initiatives; and
- Developing and implementing Equality & Diversity refresher training for staff.

Graeme Miller, Tracey Ward and Geoff Hogg, Continuous Improvement Facilitators.

Part 1: Statement on Quality from the Chief Executive

Welcome to our Quality Report for 2011/12. The report provides a valuable opportunity for us to show how we are working to put patient safety and service quality at the forefront of everything we do.

Like all NHS organisations, we faced another challenging year in terms of needing to control our spending and at the same time achieving widespread efficiencies, while improving the quality of our services. Against this background I am pleased to report that we have achieved many of the goals and commitments that we set out last year and are on track to meet many others.

During November 2011, we had our unannounced visit from the Care Quality Commission (CQC), our quality regulator. The inspection team spoke with patients and their visitors about their experiences of the hospital and the service they had received. We are delighted that they found no concerns about patient care or standards, and our staff demonstrated excellent practice in many areas.

The recent three yearly Safeguarding Children and Looked After Children inspection of health and social care agencies by the CQC was also rated as 'good'. This external assurance of the quality of our services is important to us, however we are not complacent and know that we need to continue to improve.

We have also achieved the majority of our Commissioning for Quality and Innovation (CQUIN) targets in 2011/12, which is a significant success. These are goals agreed between the hospital and our commissioners and are designed to stimulate improvement and innovation. CQUIN has a larger focus in next year's contract with our commissioners to ensure that we continue to improve year on year. I'm confident that we can do what is needed to ensure that quality of healthcare remains first on our agenda.

Through our real time feedback initiative we have been able to capture the views of over 2,000 patients in the last year. These are used by our ward teams to improve and provide better care for patients.

As promised, we have expanded real time feedback into areas such as maternity and paediatrics. It goes without saying that without the support from our network of volunteers who carry out the surveys, we wouldn't have achieved as much as we have.

We have also participated in more national clinical audits than in previous years, and through our directorate Clinical Governance Reviews, there is clear evidence that specialties and their teams are improving quality and patient safety year on year.

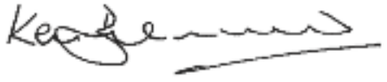
Our performance in the national patient surveys, i.e. Inpatients, Outpatient department, Neonatal Unit, continue to show that we are getting the quality of services right the vast majority of the time. Many of the surveys include comments by our patients which we take on board to help us improve further.

We are keen to ensure easy access to our services for patients and visitors and have made some significant changes to our car parking arrangements in 2011/12. Whilst these changes did present some initial difficulties, we can now show that there is much more efficient use of car parking spaces and many patients and visitors report it is much easier to find a parking space than previously.

Our annual Quality Report highlights where we have done well, and rightly, it also shows areas where we need to do better. Despite having only one case of MRSA infection this year, we did fall short for the very challenging target for *Clostridium difficile*. This was a great disappointment for all concerned. Our detailed investigations did not reveal any simple cause for the increase or any evidence of widespread failure. Our position at the year end however is more reassuring and stable. Reducing avoidable hospital infection will continue to be one of our top clinical priorities.

In reflecting on the report, staff have much to be proud of. These achievements have undoubtedly improved the care for our patients. We will of course continue to fully embrace the principle of quality improvement going into 2012/13 and I look forward to reporting on our progress next year.

To the best of my knowledge and belief, the information contained in this report is accurate.



KEN BREMNER
Chief Executive Date: 29 May 2012

Part 2: Priorities for quality improvement and statements of assurance from the Board

Review of quality and safety performance 2011/12 – "Looking back"

Our ambition remains to provide "best quality and highest safety". For our patients this means being a place where people want to come to receive care; for our staff it means being an organisation where people want to come and work.

Clinical Quality Priorities 2011/12 - Overview

Improvement Priority 1:
Clinical Effectiveness

- Reduction in avoidable hospital acquired infection
  MRSA bacteraemia
  Clostridium difficile infection

Improvement Priority 2:
Patient Experience

- Improvement of the patient experience and overall satisfaction in key areas
  – Increase food scores on quality, choice and assistance
  – Enhance the patients perception of pain management

Improvement Priority 3:
Patient Safety

- More effective management of the deteriorating patient to minimise avoidable harm
  – Improve staff recording, recognition and response to deteriorating Early Warning Scores (EWS)

Improvement Priority 4:
Patient Safety

- Reduction in the number of patient slips, trips and falls
  – To reduce the number of patient slips, trips and falls
  – To reduce the number of falls causing major injury

> "The quality of healthcare remains first on our agenda"

Priority 1: Clinical Effectiveness

Health Care Associated Infections (HCAI) are infections that are neither present (nor incubating) when a patient enters hospital. About 10% of inpatients acquire a Health Care Associated Infection, however not all HCAIs are preventable. We said we would reduce the numbers of avoidable hospital acquired infections and we are delighted with the success in achieving our target for MRSA bacteraemia, achieved through a combination of effective hand hygiene, asepsis and surveillance practices. However we are disappointed that we were not able to continue our year on year reduction in Clostridium difficile infection.

How did we do?

Indicator	07/08	08/09	09/10	10/11	11/12	Achieved / Not achieved
MRSA bacteraemia	37	33	20	8	4*	✔
Clostridium difficile	–	192	93	49	64*	✘

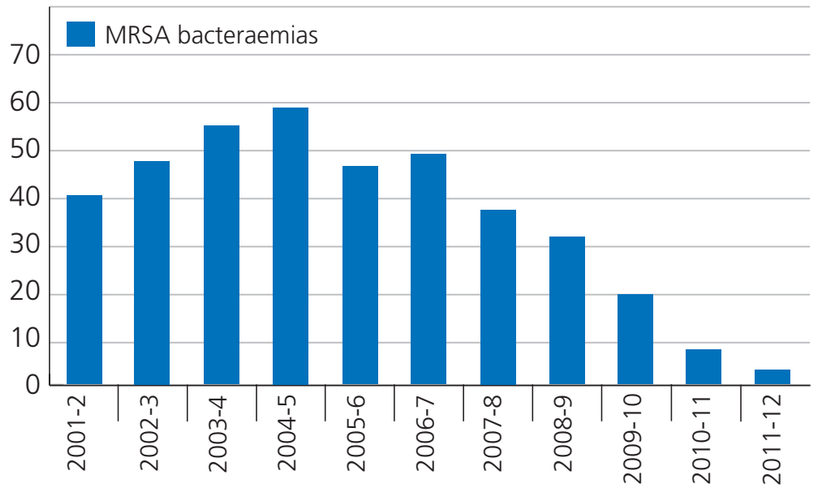
* The cases represent all MRSA cases for comparison purposes (both hospital and community acquired)

Data source: HPA Data Capture system and these are governed by standard national definitions

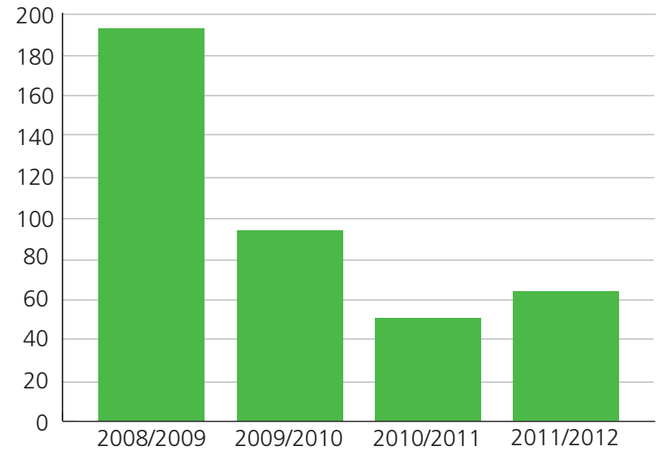
The yearly target for MRSA was 6 or fewer cases and the Trust has comfortably achieved the target with only 1 case reported (and 3 community acquired infections). We remain one of the best performing Trusts in the region for prevention of MRSA infection. However during 2011/12 we reported higher numbers of *Clostridium difficile* Associated Diarrhoea (CDAD) against our agreed targets set by Monitor, the independent regulator of Foundation Trusts. The Trust reported the position to Monitor each quarter and in January 2012 sent a detailed plan to demonstrate the actions being taken. Monitor were satisfied that the Trust was addressing the issue and there was no further escalation.

Detailed assessment of all *Clostridium difficile* cases did not reveal a simple explanation for the increase in numbers and there is no evidence of any systemic failure of control processes within City Hospitals.

MRSA bacteraemia 2001-2011



Hospital acquired C. difficile infection



Comments and progress

Maximum effort continues to be focused on keeping the risk of Clostridium difficile transmission to a minimum. During the year we have initiated a number of measures which have included:

- Rapid review of all cases of CDAD within 48 hours of diagnosis with action plans for that area;
- Where the rapid review has indicated that there may be lessons to learn the clinical team is asked to present the case for an extended discussion to the Chief Executive, Director of Infection Prevention & Control and Head of Infection Prevention & Control, amongst others. The outcomes of these meetings are then circulated to the Clinical Champions for wider dissemination of any lessons learned;
- Screening for *Clostridium difficile* in high risk asymptomatic areas;
- Environmental swabbing for *Clostridium difficile* with enhanced deep cleaning (hydrogen peroxide fogging) if *Clostridium difficile* is detected in the environment, and enhanced audit of cleaning with a review of cleaning practices by the infection control team;
- Enhanced monitoring of antibiotic prescribing to ensure that best practice is followed;
- Review of getting samples to microbiology in a more timely fashion so that there is no delay in making a diagnosis.

We have also undertaken a review of best practice in other local Trusts to ensure that there are no measures that we are missing.

Other achievements during the year

- The Trust is compliant with the Health and Social Care Act 2008 (revised 2010);
- The Infection Prevention and Control Team participated in a national one week prevalence audit of MRSA admission screening;
- The review of Infection Prevention and Control mandatory training for all staff;
- We have refreshed the hand hygiene audit programme to include the World Health Organisation '5 moments for hand hygiene' campaign;
- We have devised an enhanced audit programme for environmental cleanliness, including medical devices and equipment;
- Mandatory reporting of Methicillin-sensitive Staphylococcus aureus (MSSA) and *E.coli* bacteraemia.

Key areas for further improvement

- Completion of root cause analysis (RCA) investigations for MSSA bacteraemia to provide lessons learnt for the organisation;
- Review and develop those staff undertaking Infection Prevention and Control link roles;
- Extend surveillance activity to target multiple specialties within the Surgical Directorate and high risk medical devices;
- To launch the revised hand hygiene audit tool throughout the organisation;
- Further collaboration with the community advisory panel to promote the importance of visitors/carers contribution to the reduction of HCAI;
- Ongoing review of infection prevention and control policies, procedures and guidelines;
- Continue to achieve high standards of infection prevention and control despite bed pressures in the Trust;
- Continue to undertake reviews of lessons learned for sharing across the organisation.

Priority 2: Patient Experience

To improve patient experience and overall satisfaction in key areas

We are committed to improving the quality of patient experience and to do that, it is important that we listen to what patients and their families say about their treatment and care, in order to help us focus on where we need to improve. We said we would increase patient ratings around hospital food and improve the management of pain as reported in the national inpatient survey.

How did we do – hospital food?

Indicator	07	08	09	10	11	Improvement
"Is your food always well presented and hot enough?"	N/A	N/A	N/A	N/A	N/A	N/A
"Are you offered a good choice of food?"	79	77	75	83	8.1*	✘
"Did you get enough help from staff to eat your meals?"	71	68	68	73	7.7	✔

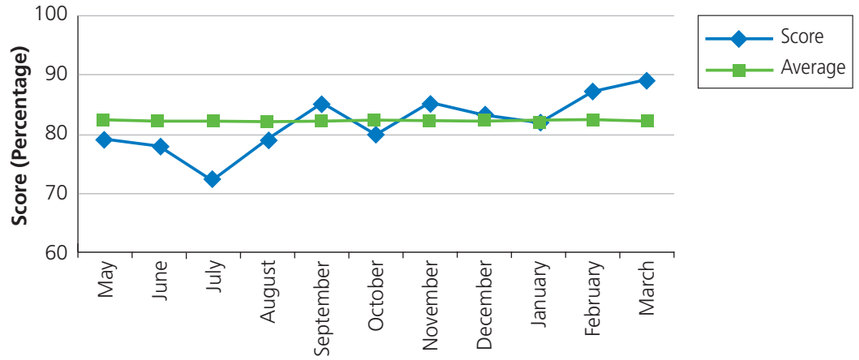
Scores are for the annual national adult inpatient surveys (Picker Institute)

N/A – no equivalent question in the national adult inpatient survey

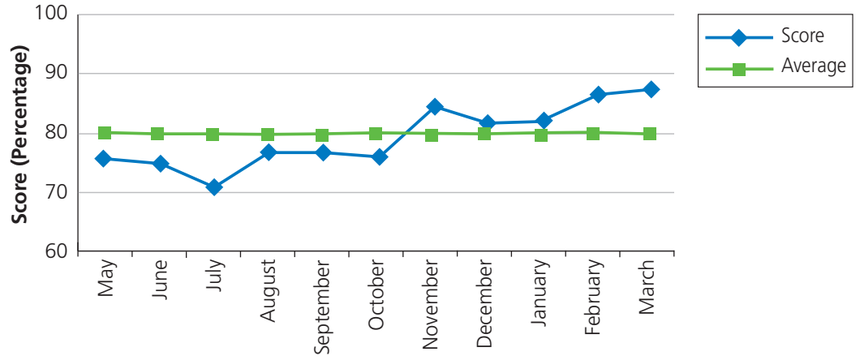
* Survey report has changed; each Trust now receives a score out of 10 for each question

The charts below show our performance as measured using the Trust real time feedback questionnaire from May 2011 to March 2012, each month a selected number of patients on each ward being asked about their hospital stay. From the responses so far we can begin to see that improvements are being made and patients are rating their mealtime experience more positively.

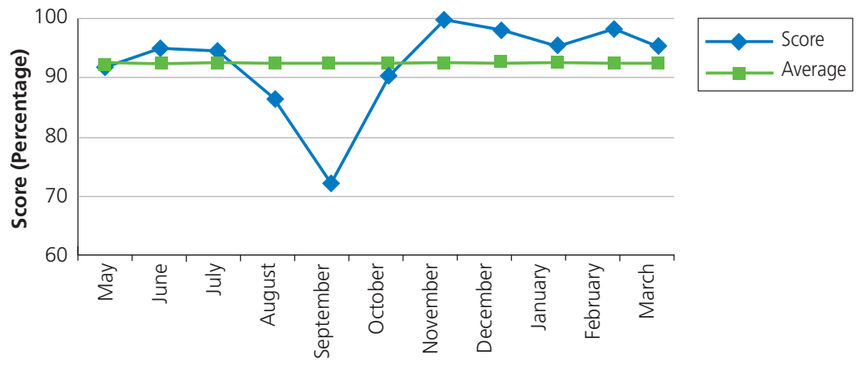
C11 – Is your food always well presented and hot enough



C12 – Are you offered a good choice of food



C13 – Did you get enough help from staff to eat your meal



Comments and progress - hospital food

A significant amount of work has been undertaken to improve patients mealtime experience. The Nutrition Steering Group is overseeing a comprehensive action plan, which includes a range of initiatives and improvements:

- Compliance with the Malnutrition Universal Screening Tool (MUST) is now more vigorously monitored by Ward Managers and Matrons;
- Introduction of visual prompts (knife & fork icons) at ward level for patients who require assistance;
- Introduction of the red tray system to promote patient assistance and recording of the amount of food eaten;
- Patients have a choice of food from an accessible menu of food and alternative choices;
- Information about nutrition and hydration for patients is included in the new 'Your Stay In Hospital' bedside folder;
- Milky drinks are available to complement tea or coffee;
- Exploring the provision of snack boxes and reviewing the potential role for volunteers to assist at meal times; and
- The clinical environment is being enhanced through the development of dining facilities at ward level.

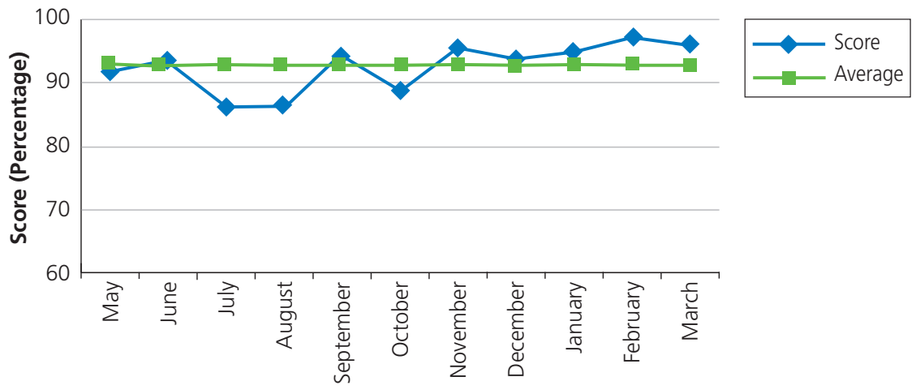
An unannounced visit by the Care Quality Commission and inspection of Outcome 5 from the Essential Standards of Quality & Safety framework (Meeting nutritional needs) in November 2011 reported no concerns with compliance with the standard.

How did we do – patient's pain experience?

Indicator	07	08	09	10	11	Improvement
"Do you feel staff do everything they can to manage your pain?"	80	79	80	79	8.1*	✔

* Survey report has changed; each Trust now receives a score out of 10 for each question

C09 – Do you feel staff do everything they can to manage your pain



Comments and progress - pain management

The Pain Management Group has revised its membership and agreed a programme of work which includes a number of new developments and changes in ward practices:

- Specific pain related objectives are included in nursing staff's performance objectives 2011/12 e.g. all patients with pain scores of 3 or more are expected to have a pain management log in place;
- Pain policies and protocols have been reviewed and updated by our acute pain nurses to ensure compliance with best practice, such as those highlighted by NICE etc;
- Specific pain education and training has been delivered by the acute pain team to all groups of staff, including junior doctors (F1, F2), newly qualified nurses, and health care assistants etc;
- Commenced a series of monthly pain score audits undertaken by Matrons (commenced by the Matron Team from June 2011);
- In order to improve patient care and experience a pain management pilot using the RADAR (Responsibility, Anticipation, Discussion, Assessment and Response) principles of pain management was successfully piloted in September 2011. Real time feedback from the pilot areas have shown improved scoring as reported by patients regarding their pain management;
- Meetings are being held with the Directorate of Surgery Matron and other key staff to plan a roll-out of RADAR into other wards.

Priority 3: Patient Safety

To improve the management of the deteriorating patient

Hospital staff are increasingly faced with the challenge of providing medical and surgical care to the very ill and an ageing population with multiple conditions. In the Trust, early warning score systems (EWS) are in place to help identify patients whose health may suddenly become worse. Incidents reported by staff and information from our local audits and review of mortality cases have sometimes shown that patients observations were not always recorded in a timely manner and that, on occasion, patients early warning scores were not acted upon in time to prevent further deterioration. Last year we said we would improve staff recording, recognition and response to deteriorating early warning scores.

How did we do?

Indicator	08	09	10	11	
Early Warning Score (EWS) was recorded accurately	81%	91%	95%	94%	✘
Patients with a documented monitoring plan	nm*	77%	93%	97%	✔
Patients had the minimum required frequency of observations / EWS in accordance with their level of care	nm*	nm*	nm*	96%	-
Monitoring plans were adhered to overnight	nm*	79%	72%	83%	✔

Data source: CHS Level of Care / Early Warning Score Point Prevalence Study (governed by national standard definitions)

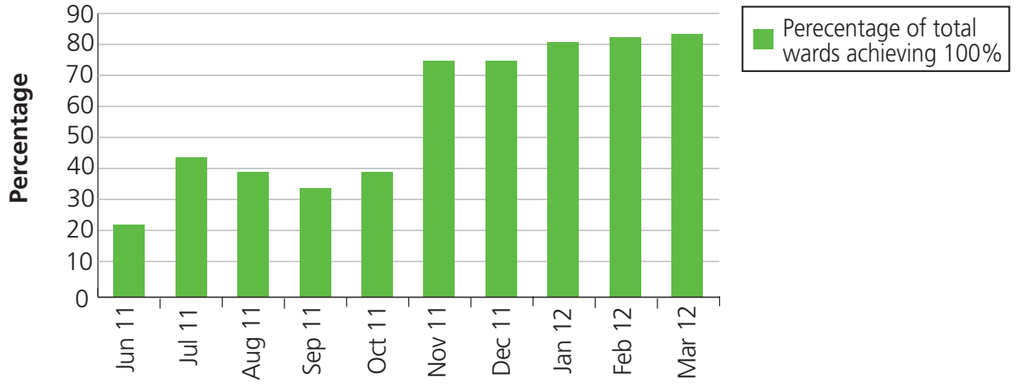
* nm – not measured because it was not part of the survey at the time

Comments and progress

Over the last few years, our annual 'Level of Care' studies have shown ongoing improvement in the accuracy of staff recording of the EWS, although a very slight dip occurred this year. The marked improvement from 2008 is, in part, attributable to the re-design and implementation of a new hospital observation chart.

NICE (2007) recommends that each patient has their own individual monitoring plan, based on their level of care and current clinical condition. This must be documented on the front of the patients observation chart and reviewed whenever there is a change in the patient's clinical condition. Figures show significant improvement in the percentage of patients having a documented monitoring plan, from 77% in 2009 to 97% in the latest study. The majority of monitoring plans are being adhered to (90%), which is good for patient safety, but we know we still have further to go to achieve full compliance.

The table below also shows the increasing numbers of wards which are achieving 100% in the monthly observation and EWS audits (national standard definitions).



The Critical Care Outreach Team (CCOT) provides an important support for ward staff in the detection and management of critically ill patients. If a patient's EWS is of concern and their condition continues to deteriorate the Team may be asked to assist with treatment on the ward. Their involvement has played a significant part in helping to improve the management of the acutely ill or deteriorating patient throughout the organisation.

Additionally, the Practitioner-Lecturer for Critical Care has devised a comprehensive and robust acute and critical care education strategy, which aims to address the learning needs of all practitioners working on acute adult wards and departments within the Trust. The purpose of this strategy is to ensure that we have an appropriately trained workforce, equipped with the knowledge and skills to competently manage the demands of acutely ill patients in City Hospitals. CCOT contribute to the rolling programme of educational courses delivered throughout the Trust.

A number of additional measures have been put in place which will further improve this area, these include:

- Making patient's vital signs and accurate recording of EWS an explicit measure within the organisation's level 1 OGSM (strategic planning framework used by the Trust to define its key objectives);
- The involvement of an Improvement Facilitator (LEAN Team) is helping to analyse and identify areas which are not achieving the required standards and each ward receives an individual report on their performance;
- The Trust's Deteriorating Patient Group has been re-configured and a new programme of work has been agreed, including a new system of monthly audits of observations and EWS within each in-patient area, with results centrally collated and monitored; and
- Specific deteriorating patient criterion within the revised NHSLA Risk Management Standards (2012).

Priority 4: Patient Safety

To reduce the number of patient slips, trips and harmful falls

Patients of all ages can fall in hospital but the rate is likely to be higher in the elderly, particularly when they are acutely unwell. Of particular concern are those falls where actual harm occurs, such as fractures, as these prolong hospital stay and may decrease the likelihood of a return to previous levels of independence. Patient falls are among the most common incidents reported in hospital and are a leading cause of death in people aged 65 or older. The goal for 2011/12 was to reduce the incidence of falls by 10% and reduce the number of harmful falls that result in major injury.

How did we do?

Indicator	08/09	09/10	10/11	11/12
Number of falls (including slips and trips)	-	1825	1636	1645
Number of falls (with associated injury*)	26	42	54**	35

Data source: City Hospitals' 'Safeguard' system

* Incident impact moderate (3) and high (4) - a patient sustaining a moderate, major and catastrophic injury (using NPSA definitions)

** The figure has been readjusted (from 57) since 3 investigations were completed after the year

Comments and progress

- Numbers of falls – unfortunately we have unable to reduce the total number of reported falls (including slips and trips) this year and in fact we have had a small increase. The reasons why we did not reach our target will be thoroughly reviewed by the Trust Falls Group and action taken.
- We reduced by 35% the number of patient falls that had associated injury. This is a welcome and important outcome but we do recognise that more work is required and this is why reducing patient falls will continue to be one of our priorities next year.
- As part of our Commissioning for Quality and Innovation (CQUIN) scheme, the Trust has achieved and surpassed the quarterly targets set for the percentage of adult inpatients with a falls high risk score and documented action plan (see Section 3 for further information).
- We have introduced a Level 1 and 2 Falls teaching package for Health Care Assistants to help improve falls prevention, risk assessment and management practice in the wards.
- We hold bi-monthly Falls awareness sessions to raise staff awareness and clarify the roles and responsibilities of link nurses.
- We have introduced a 'High Risk Fallers' stamp to identify those patients with a particular falls risk; this is also flagged on our HISS bulletin board (our electronic hospital information system).

Priorities for quality improvement in 2012/13 – "Looking forward"

As in last year's Quality Report, we have grouped our priorities and plans under the three main quality headings; patient safety, clinical effectiveness and patient experience. In choosing our priorities, we have reviewed and reflected on our performance in 2011/12 and considered the following factors:

- Areas where we know our current performance is lacking and still needs to improve,
- Areas which we believe can make a positive impact on patient experience and the quality and safety of our services,
- Areas which can be monitored and measured, so we will be able to clearly show where improvements have been made,
- Areas which have a strong connection and alignment with our Trust strategic priorities for 2012/13.

Improvement Priority 1:
Clinical Effectiveness

- Reduction in avoidable hospital acquired infection
  - MRSA bacteraemia / MSSA bacteraemia
  - *Clostridium difficile* infection

Improvement Priority 2:
Patient Experience

- Improvement of the patient experience and overall satisfaction in key areas
  - Increase food scores on quality, choice and assistance
  - Enhance the patients perception of pain management

Improvement Priority 3:
Patient Safety

- More effective management of the deteriorating patient to minimise avoidable harm
  - Improve staff recording, recognition and response to deteriorating Early Warning Scores (EWS)

Improvement Priority 4:
Patient Safety

- Reduction in the number of patient slips, trips and falls
  - To reduce the number of patient slips, trips and falls
  - To reduce the number of falls causing major injury

Improvement Priority 1: Clinical Effectiveness - Reduction in avoidable hospital acquired infection

Reducing healthcare acquired infections has been one of our top priorities for some time and we have been very successful in reducing avoidable infections. Whilst we achieved our targets for MRSA this year, we did fail to meet our very challenging *Clostridium difficile* targets, despite previous year on year improvements.

Evidence shows hospital infection is one of the most important factors influencing confidence in care that patients consider prior to coming into hospital. We believe that one patient with any avoidable infection is one patient too many. This is why we will continue to keep hospital acquired infection a top priority.

For 2012/13, the Trust has been set an even more challenging target of:

- not exceeding 1 post-48 hours MRSA bacteraemia; and
- not exceeding 44 post-72 hours cases of *C. difficile* infections.

In addition we will monitor the incidence of MSSA (Methicillin-resistant Staphylococcus aureus) bacteraemia. There has been no target set for 2012/13. Currently, infection rates for MSSA in City Hospitals show high standards of infection prevention and control, particularly with regard to aseptic technique and many of the actions that are appropriate for preventing MRSA infections are also applicable to MSSA.

How progress will be:	
Measured	• Number of reported and confirmed cases of MRSA bacteraemia (post-48 hours) and Clostridium difficile (post-72 hours) • Number of reported cases of MSSA
Monitored	• Director of Infection Prevention & Control (DIPC)/ Infection Control Doctor/ Head of Performance • Strategic Infection Prevention and Control Group • Clinical Governance Steering Group
Reported	• Corporate dashboard • Clinical Governance Steering Group • Board of Directors

Improvement Priority 2: Patient Experience - mprovement of the patient experience in key areas

Although patients are telling us that we are getting it right most of the time, there are occasions where we have not lived up to their or indeed our expectations. Despite our best efforts last year, feedback from patients still shows that they have concerns about some areas of their care and treatment. Enhancing patients' hospital experience is high among our key organisational priorities and we are fully committed to hearing about their experiences and addressing their personal concerns.

Last year we focused on improving patients rating and choice of hospital food and our management of their pain. Our audits and survey information showed we made only modest improvements and there is evidence that variations in practice still exist across wards and departments. This is why we will continue to focus on hospital food and pain management during 2012/13.

How progress will be:	
Measured	• National Adult Inpatient Survey 2012 • Real time feedback • Number of reported incidents and complaints
Monitored	• Monthly real time feedback reports and cumulative scorecards • Patient and Public Involvement Committee
Reported	• Patient and Public Involvement Committee • Board of Directors • Board of Governors

Improvement Priority 3: Patient Safety - More effective management of the deteriorating patient to minimise avoidable harm

We have already highlighted that deterioration of patients in hospital is frequently preceded by documented deterioration of their vital signs. Failure of clinical staff to recognise and respond to these signs and summoning appropriate medical help will put patients at risk. That is why accurate recording of the Early Warning Score (EWS) is important and taking prompt action can help avoid serious problems.

We have seen from our internal monitoring increased percentages of patients having their EWS recorded accurately, more patients having the right monitoring plans in place and increasing numbers of wards which are achieving 100% in the monthly observation and EWS audits. This is encouraging and we are certainly moving in the right direction but we want to be certain that our practices, for managing patients who unexpectedly get worse, are fully understood and implemented. For these reasons we will continue to have this as one of our clinical priorities in 2012/13.

How progress will be:	
Measured	• Annual level of care report • Monthly early warning score (EWS) audits
Monitored	• Reported incidents of patient deterioration • Deteriorating Patient Group
Reported	• Clinical Governance Steering Group • Governance Committee • Board of Directors

Improvement Priority 4: Patient Safety - Reduction in the number of patient slips, trips and falls

Slips, trips and falls continue to be our largest clinical risk and, once again, the most vulnerable are older people, particularly when they are unwell. The prevention of falls in hospital is complex and there is no single solution to their reduction. Success depends on integrating a range of strategies and approaches to identifying which patients are most 'at risk' and then putting measures in place for prevention through multi-disciplinary working.

During 2012/13 the national focus on falls will be enhanced with the mandatory collection of data on falls as part of the NHS Safety Thermometer (audit tool); falls will also be part of our CQUIN scheme in 2012/13. Against this background we will retain this important area as a priority next year.

Our goal will be to reduce the number of falls among our in-patients and reduce the number of falls that result in moderate and major injury (using NPSA definitions).

How progress will be:	
Measured	• Incident reporting system (Internal Safeguard system)
Monitored	• Trust Falls Group
Reported	• Clinical Governance Steering Group • Governance Committee • Board of Directors

Indicators for quality improvement 2012/13

In addition to these quality priorities, after consultation with clinical teams and various internal quality committees and patient groups, we have also agreed to measure, monitor and report on the following indicators for quality improvement in 2012/13.

Patient Safety			
Metric	Description	Rationale	Monitoring group
Hospital mortality	To reduce avoidable mortality	• Worse than expected' mortality in CQC Quality & Risk Profile • National Outcomes Framework (Outcome 1)	Clinical Governance Steering Group
Discharge arrangements	Improve the quality and timeliness of discharge communication between the Trust and Primary Care	• GP survey (2010) • Issues previously raised by LINk and the PCT	Operational Management Group
Never Events	Eliminate any occurrence	• Operating Framework • National Never Event Programme	Clinical Governance Steering Group

Clinical Effectiveness			
Metric	Description	Rationale	Monitoring group
Hospital readmissions	To reduce the number of avoidable emergency readmissions, i.e. COPD	• Penalty schedule • National Outcomes Framework (Outcomes 2 & 3)	Operational Management Group
Reporting times for Radiology	Improve reporting times to GPs for X-rays and ultrasound scans	• Radiology Clinical Governance Review • Complaints from PCT • Outcome of G.P survey 2010	Operational Management Group
End of Life	Increase the number of patients on the Liverpool Care Pathway (LCP) as a proportion of those expected to die	• CQUIN 2011/12 metric	End of Life Steering Group
Venous Thromboembolism	All patients, on admission, receive an assessment of VTE and bleeding risk and high risk patients are given appropriate prophylaxis	• Mandatory CQUIN indicator • NICE Quality Standard • National Outcomes Framework (Outcome 5)	Venous Thromboembolism Group

Patient Experience			
Metric	Description	Rationale	Monitoring group
Overall	Increase the % of patients who reported "Overall how would you rate the care you received" (% of patients who said 'Good' and above)	• DH National Inpatient Survey programme	Patient & Public Involvement Committee
Privacy & dignity	Maintain or improve patient experience of privacy & dignity in wards and outpatient departments	• National Outpatients Survey 2011/ Inpatient Survey 2011 • National Outcomes Framework (Outcome 5) • Complaints about communication	Patient & Public Involvement Committee
Medication side effects	Staff to explain medication side effects to patients	• DH National Inpatient Survey • Poor scores in internal Real Time Feedback	Patient & Public Involvement Committee
Outpatients Department	Reduction in the % and number of cancelled appointments and repeat cancellations	• National Outpatient Department Survey	Performance & Information Services

Statements of assurance from the Board

Information on the review of services

During 2011/12 City Hospitals Sunderland provided and/or sub-contracted 40 NHS services.

City Hospitals Sunderland has reviewed all the data available to them on the quality of care in 46% of these NHS services during 2011/12 (via submission of a 2-yearly Clinical Governance Review).

The income generated by the NHS services reviewed in 2011/12 represents approximately 49% per cent of the total income generated from the provision of NHS services by City Hospitals Sunderland for 2011/12.

The data reviewed within the Clinical Governance Review covers the three dimensions of quality; patient safety, clinical effectiveness and patient experience, and includes for example:

- Management of clinical incidents and risks to improving patient safety,
- Adherence to national and local infection control guidelines,
- Participation in national and local clinical audits and changes made to practice,
- Acting on the findings from complaints and patients surveys,
- Evidence that national 'best practice' is being followed, i.e. implementation of NICE guidelines,

Submission of a specialty Clinical Governance Review is in accord with a two-yearly cycle that is presented to the Clinical Governance Steering Group. The reviews provide a robust and valuable way of 'sense checking' the clinical performance of our services, highlighting quality issues and risks that need to be addressed but also publicising examples of good practice.

NHSLA Risk Management Standards for NHS Trusts Providing Acute Services 2011/12

The NHS Litigation Authority (NHSLA) conducts rigorous assessments of NHS organisations against a set of core Risk Management Standards. The standards and assessment processes are designed to provide a structured framework to focus the organisation's risk management activities on delivering improvements in governance, patient care and the safety of patients, staff and visitors.

Last year we reported that we fell short in complying with the Level 2 standards and in order to undertake another Level 2 assessment we had to retain our Level 1 status. On the 14th September 2011, the Trust underwent a Level 1 assessment and successfully achieved its Level 1 position (Level 1 assessment is concerned with minimum standards contained within Trust corporate and clinical policies).

The organisation was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1 the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The scores awarded were as follows:

NHSLA Standards domain	Score	Status
Governance	10/10	Compliant
Competent & Capable Workforce	8/10	Compliant
Safe Environment	10/10	Compliant
Clinical Care	9/10	Compliant
Learning from Experience	10/10	Compliant
Overall Compliance	**47/50**	**Compliant**

Accreditation schemes

The NHS has an established system of accreditation schemes that ensure hospital services meet national standards of service delivery and quality. These schemes usually involve self-assessment and/or external audit which are confirmed by external peer review. The following highlights the outcomes of accreditation schemes undertaken this year by some of our clinical services:

- Joint Advisory Group (JAG) on Gastro-intestinal (GI) Endoscopy - The JAG on GI Endoscopy ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised in the UK. It operates within the Clinical Standards Department of the Royal College of Physicians. The JAG assessment is carried out across 6 main domains: consent, safety, comfort, quality, appropriateness and timeliness.

  These domains are monitored through a six monthly online self assessment process using a global rating score (GRS) that measures the quality of the service (in multiple areas). To maintain JAG accreditation the aim is to score "B" across the domains but with an "A" for timeliness. The domain scores are reviewed frequently (including the six monthly self assessment) to ensure appropriate scores to maintain accreditation. A portfolio of evidence is built up year by year to demonstrate good practice and is reviewed by JAG every five years during an inspection visit. The latest GRS report suggests that the Trust has further work to do in some key areas in order to renew its JAG accreditation in 2012.
- Clinical Pathology Accreditation (UK) Ltd - The Pathology laboratories, comprising Haematology and Blood Transfusion, Biochemistry, Histopathology and Cytology, and Microbiology have current accreditation with Clinical Pathology Accreditation (UK) Ltd (CPA). This is the internationally recognised body providing quality standards. Accreditation is reviewed bi-annually. The blood transfusion service also operates under the supervision of the MHRA (Medicines and Healthcare products Regulatory Agency) and the Trust is compliant with the standards.

External assessment and visits

- Rheumatology - The Northern Region Rheumatology Group undertook a peer review of the Rheumatology department at Sunderland Royal Hospital in February 2012. The British Society of Rheumatology (BSR) suggests a Peer Review is carried out every 5 years. The review looks at compliance with BSR standards of care for rheumatology patients and also NICE guidance and focuses on all staff within the multidisciplinary team, i.e. clinicians, management, nursing staff, physiotherapy, occupational therapy and podiatry.

The report from the review summarises:

"This is a fairly young unit with an enthusiastic team of staff across all the disciplines. They claim to be patient-centred and this was very visible throughout the day. Clinical care is delivered to a high standard and knowledge is clearly up to date with best evidence and NICE guidance acting as cornerstones for service development."

National Cancer Peer Review

National Cancer Peer Review (NCPR) is a national quality assurance programme for NHS cancer services. The programme involves both self-assessments by cancer service teams and external reviews of teams conducted by professional peers, against nationally agreed "quality measures". During 2011/12 the following tumour sites within the Trust's Cancer Services were assessed:

Tumour site	Compliance (%)	Type of assessment
Head & Neck MDT	76.0	Formal Peer Review visit
Head &Neck Locality	78.0	Formal Peer Review visit
Thyroid MDT	93.0	Formal Peer Review visit
Teenage & Young Adults (TYA)	50.0	Self assessment (SA) with external verification (EV)
Penile	75.0	Self assessment (SA) with external verification (EV)
Gynaecology locality	80.0	Self assessment (SA) with external verification (EV)
Chemotherapy services	85.4	Self assessment (SA) with external verification (EV)
Oncology Pharmacy	100.0	Self assessment (SA) with external verification (EV)
Intrathecal Chemotherapy	100.0	Self assessment (SA) with external verification (EV)
Colorectal	89.7	Self assessment (SA) with internal validation (IV)
Colorectal locality	100.0	Self assessment (SA) with internal validation (IV)
Brain/Central Nervous System	100.0	Self assessment (SA) with internal validation (IV)
Sarcoma Locality	100.0	Self assessment (SA) with internal validation (IV)
Breast	80.6	Self assessment (SA) with internal validation (IV)
Specialist Urology	90.7	Self assessment (SA) with internal validation (IV)
Acute Oncology MDT	66.7	Self assessment (SA) with internal validation (IV)
General Acute Oncology	54.6	Self assessment (SA) with internal validation (IV)
Inpatient Acute Oncology	75.0	Self assessment (SA) with internal validation (IV)
Lung	85.2	Self assessment (SA) with internal validation (IV)
Upper Gastro Intestinal (UGI)	76.7	Self assessment (SA) with internal validation (IV)

Action plans have been issued to each multidisciplinary team and meetings commenced to feed back compliance levels and requirements relating to improved documentation. For example, the Acute Oncology Service is developing a neutropenic sepsis pathway for patients with low white cells who have an infection; implementing a patient alert database for emergency admission following chemotherapy and the service is working with specialists within the PCT to implement a new pathway for metastatic spinal cord compression.

There were two tumour sites subject to a formal Peer Review visit in 2011, split into local Multidisciplinary Team (MDT) and Locality measures:

- Head & Neck MDT and Head & Neck Locality – The areas of good practice highlighted by the Peer Review assessors included:
  - Achieved cancer wait targets;
  - Cohesive cross-specialty team working;
  - Speech & Language support;
  - Mouth cancer awareness campaign;
  - Robust palliative care attendance at MDT;
  - Strong links with haematology and lung MDTs;
  - Close collaboration between Sunderland and Newcastle histopathologists; and
  - No immediate risks identified.

Areas for improvement included:

  - Clinical Nurse Specialist not always present at breaking of bad news to patients;
  - No ward sister/charge nurse identified as a core member of MDT;
  - Not all neck lump clinics have access to ultrasound guided biopsy; and
  - Turnaround times for PET CT (produces a three-dimensional image or picture of the body) need to be monitored closely to ensure no delays in the treatment pathway.

These are being actioned through the relevant multidisciplinary group.

- Thyroid MDT (Thyroid MDT at CHS is a sub-group of the specialist MDT at Newcastle, therefore formal visit and assessment was carried out at Newcastle General Hospital) – A brief summary of the report (extracted from the Newcastle self assessment report) concludes:
  - The MDT has had many innovations and achievements,
  - Excellent performance against Cancer Waiting Time Standards,
  - Strong patient centred focus with development of links to patient/carer groups,
  - Commitment to maintaining strong clinical trials portfolio,
  - No immediate risks,
  - No serious concerns.

Participation in clinical audit and national confidential enquiries

During 2011/12, 43 national clinical audits and 4 national confidential enquiries covered NHS services provided by City Hospitals Sunderland.

During 2011/12 City Hospitals Sunderland participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that City Hospitals Sunderland participated in, and for which data collection was completed during 2011/12, are listed overleaf alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

National Clinical Audits	Eligible	Participation	Compliance
Peri and neonatal care			
Perinatal mortality (CEMACH)	✔	✔	Continuous data collection[1]
Neonatal intensive and special care (NNAP)	✔	✔	Continuous data collection
Children			
Paediatric pneumonia (British Thoracic Society)[2]	✔	✘	No data submitted
Paediatric asthma (British Thoracic Society)	✔	✔	100% compliance. 24 cases submitted
Pain management (College of Emergency Medicine)	✔	✔	100% compliance. 50 cases submitted
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✔	✔	100% compliance. 30 cases submitted + user experience survey
Paediatric intensive care (PICA Net)	N/A	N/A	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	N/A	N/A	N/A
Diabetes (RCPH National Paediatric Diabetes Audit)	✔	✔	Continuous data collection
Acute care			
Emergency use of oxygen (British Thoracic Society)	✔	✔	100% compliance. Organisational data and 40 cases submitted
Adult community acquired pneumonia (British Thoracic Society)[3]	✔	✘	No data submitted
Non invasive ventilation - adults (British Thoracic Society)[3]	✔	✘	No data submitted
Pleural procedures (British Thoracic Society)[3]	✔	✘	No data submitted
Cardiac arrest audit	✔	✔	Continuous data collection
Severe sepsis & septic shock (College of Emergency Medicine)[2]	✔	✘	No data submitted
Adult critical care (ICNARC CMPD)	✔	✔	Continuous data collection
Potential donor audit (NHS Blood & Transplant)	✔	✔	Undertaken by the Blood Centre, Newcastle
Seizure management (National Audit of Seizure Management)	✔	✔	100% compliance. Organisational data and 30 cases submitted
Long term conditions			
Diabetes (National Adult Diabetes Audit)	✔	✔	Continuous data collection
Heavy menstrual bleeding (RCOG National Audit of HMB)	✔	✔	100% compliance
Chronic pain (National Pain Audit)	✔	✔	Continuous data collection
Ulcerative colitis & Crohn's disease (UK IBD Audit)	✔	✔	100% compliance. Organisational data and 40 cases submitted
Parkinson's disease (National Parkinson's Audit)	✔	✔	100% compliance. 20 cases submitted
Adult asthma (British Thoracic Society)	✔	✔	100% compliance. Organisational data and 11 cases submitted
Bronchiectasis (British Thoracic Society)	✔	✔	100% compliance 13 cases submitted
Elective procedures			
Hip, knee and ankle replacements (National Joint Registry)	✔	✔	Continuous data collection
Elective surgery (National PROMs)	✔	✔	Continuous data collection
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A

[1] The Trust is participating in the audit; data is collected on a continual basis rather than a sample of patients.
[2] Not able to participate this year because of limited time and resources.
[3] Not able to undertake all BTS audits but managed to participate in more audits than 2010/11.

National Clinical Audits	Eligible	Participation	Compliance
Liver transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	✔	✔	Continuous data collection
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✔	✔	Continuous data collection
Carotid interventions (Carotid Intervention Audit)	✔	✔	Continuous data collection
CABG and valvular surgery (Adult cardiac surgery audit)	N/A	N/A	N/A
Cardiovascular disease			
Acute Myocardial Infarction & other ACS (MINAP)	✔	✔	Continuous data collection
Heart failure (Heart Failure Audit)	✔	✔	Continuous data collection
Acute stroke (SINAP)	✔	✔	Continuous data collection
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	✔	✔	Continuous data collection
Renal disease			
Renal replacement therapy (Renal Registry)	✔	✔	Continuous data collection
Renal transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
Cancer			
Lung cancer (National Lung Cancer Audit)	✔	✔	Continuous data collection
Bowel cancer (National Bowel Cancer Audit Programme)	✔	✔	Continuous data collection
Head & neck cancer (DAHNO)	✔	✔	Continuous data collection
Oesophago-gastric cancer (National O-G Cancer Audit)	✔	✔	Continuous data collection
Trauma			
Hip fracture (National Hip Fracture Database)	✔	✔	Continuous data collection
Severe trauma (Trauma Audit & Research Network)	✔	✔	Continuous data collection
Psychological conditions			
Prescribing in mental health services (POMH)	N/A	N/A	N/A
Schizophrenia (National Schizophrenia Audit)	N/A	N/A	N/A
Blood transfusion			
Bedside transfusion (Comparative Audit of Blood Transfusion)	✔	✔	Partial compliance - only submitted 21 cases (recommended 70)- 30%*
Medical use of blood (Comparative Audit of Blood Transfusion)	✔	✔	100% compliance – submitted 90 cases
Health promotion			
Risk factors (National Health Promotion in Hospitals Audit)	✔	✘	Did not participate
End of life			
Care of dying in hospital (NCDAH)	✔	✔	100% compliance. Organisational data and 50 cases submitted.

* Partial compliance, pressure on internal staff resource meant that study sample was not achieved.

National Confidential Enquiries 2011/12

The National Confidential Enquiries are a form of national clinical audit which examines the way patients are treated in order to identify ways to improve the quality of care. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is concerned with maintaining and improving standards of medical and surgical care.

During 2011/12 City Hospitals were eligible to enter data into 4 NCEPOD studies. The table below provides a summary of our participation.

Confidential Enquiry	Cases included	Prospective forms returned	Questionnaires returned	Case notes returned	Sites participating	Organisational questionnaire returned
Bariatric Surgery	6	N/A	6	6	2	0
Cardiac Arrest Procedures	8	8	8	8	2	2
Peri-operative Care	7	143*	n/a	7	2	2
Surgery in Children**	0	0	0	0	2	2

* This was a prospective study and, this is the total number from which a sample of 7 cases only were required to be reviewed

** No children fulfilled the study criteria during the time frame

Summary of national clinical audits

The reports of 13 national clinical audits were reviewed by the Trust in 2011/12 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

National Audit of Dementia (Care in General Hospitals)

The National Audit of Dementia examines the quality of care received by people with dementia in the general hospital environment. It reviews what structures and resources hospitals have in place to enable them to identify and meet the care needs of people with dementia and shows whether people with dementia have received an acceptable standard of care. Since the inaugural audit was undertaken in 2010 (and the results published in 2011), City Hospitals has implemented several initiatives including:

- Establishing a mental health liaison service with 5 mental health nurses to cover Sunderland and South Tyneside. The service will be responsible for a number of supportive activities for the dementia service, including referral for a psychiatric consultation;
- The development of an e-learning programme comprising modules for the Mental Capacity Act, Deprivation of Liberty and Safeguarding;
- The introduction of a mental health awareness session for all staff delivered at Trust induction;
- The reinstatement of the 'butterfly prompt' system to enable all staff to recognise those patients with dementia problems who require additional help and support;
- As a result of collaborative work with the Trust's Pain Group, the introduction of a Trust wide dementia patient pain tool;
- The introduction of the 'This is me' document to all wards within the Trust;
- The development of Trust policies and the accompanying relevant documentation in relation to the Mental Capacity Act, Deprivation of Liberty and Safeguarding;
- The introduction of an electronic core care plan for all confused patients and Mini-Mental State Examination (MMSE) is now included in the patient's electronic record; and
- The spread of luncheon clubs across the Trust to complement existing systems and ensure patients' nutritional needs are met.

UK Inflammatory Bowel Disease (IBD) Organisational Audit

The IBD Audit seeks to improve the quality and safety of care for IBD patients in hospitals by auditing individual patient care and the provision and organisation of IBD service resources. City Hospitals compares favorably with peers in some specific areas with good service provision being maintained or improved over the last 2 years. Improvements have included;

- The involvement of a named pharmacist with an interest in IBD attached to the IBD team;
- The initiation of a Multidisciplinary Nutrition Team to support the specific nutritional needs of IBD patients;
- Established pathways for the admission of IBD patients directly to the Gastroenterology ward;
- Trust guidelines for the management of severe acute colitis;
- The introduction of parallel Gastroenterology/Surgical IBD clinics. Work is progressing to review job plans and to finalise times of clinics;
- The introduction of a transition clinic for patients moving from paediatric to adult services which offers joint review of patients at or before handover of care.

National Kidney Care Audit (Vascular Access)

The aims of the audit are to determine the performance of renal centres in the use of vascular access (the means by which the blood circulation of a patient may be accessed) for haemodialysis, to measure the burden of vascular access and to explore operational issues in providing access. The results for City Hospitals Renal Department are very positive and reflect the hard work that is undertaken by the multidisciplinary team to prepare patients for haemodialysis.

The Renal Department has implemented the new renal IT system (Clinical Vision 5) which will help with continued participation in this important audit. The team are working with the interventional radiology department to maintain our high vascular access (graft) rates in the haemodialysis population.

Our medical records library holds in excess of half a million patient records.

National Lung Cancer Audit (LUCADA)

Our performance in the national audit is improving both internally and against regional and national trends. In terms of improvements of the cancer pathway we have;

- Re-engineered service delivery with the development of more access to fast track cross sectional imaging; and
- Developed EBUS-TBNA (endobronchial ultrasound-transbronchial needle aspiration) allowing a one stop diagnosis and staging of lung cancer cases. This service is now generating external referrals from within the Cancer Network.

National Audit of Diabetes Inpatients

Following results of the audit and the launch of the Joint British Diabetes Societies guidelines in 2010 the department has developed and implemented several new protocols and initiatives including:

- An updated integrated care pathway for the management of diabetic ketoacidosis, ensuring correct diagnosis, fluid and insulin therapy which will result in a reduction of the patient's length of stay;
- Further protocols to manage other hyperglycaemic emergencies;
- A new hypoglycaemia protocol with the introduction of a 'hypo box' distributed to every ward and department;
- An integrated foot care pathway alongside a diabetes foot assessment tool;
- Guidance for the peri-operative management of patients with diabetes undergoing surgery;
- The introduction of new insulin prescribing charts to try to reduce the number of insulin prescribing errors. In addition a formative assessment programme in combination with the NHS Diabetes e-learning module has been introduced for foundation level doctors; and
- All new insulin prescribing charts and other diabetes hospital protocols are compliant with NPSA 13 on the safe use of insulin.

Children and young people with cerebral palsy in Northern England ('Building Better Futures')

City Hospitals participated in a regional audit of services for children and young people with cerebral palsy. The Trust's performance in the audit was exceptional and is testimony to the extremely high standards of care that we provide to this very complex and challenging group of patients. Our current multidisciplinary approach, including access to a specialist orthopaedic opinion, is second to none in the region. Other aspects of the care pathway show that we provide an exemplar service for children and young people with cerebral palsy in Sunderland.

Local clinical audit

The reports of 130 local clinical audits registered with the Clinical Governance department were reviewed by the provider in 2011/12 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided:

- The development of an information pack for patients attending the low clearance clinic in Renal (for those with impaired kidney function) to help them make an informed decision about their future treatment;
- Haematology and Microbiology are working together to refine the use of Procalcitonin assay (special blood test) in a selected population of patients who are febrile and undergoing treatment for malignancies;
- The introduction of a standardised neutropenic sepsis pathway (fever in patients with low white blood cells) with accompanying clear and concise documentation;
- The development and implementation of patient group directions for the management of chemotherapy toxicities and neutropenic sepsis (these allow certain health professionals to supply and administer specified medicines to particular patients);

Following an audit which looked at the current management pathway of patients with malignant otitis externa (inflammation of the outer ear and ear canal), we have introduced a new pathway of care. This should help reduce patients' length of stay significantly and also reduce the number of cannulas patients have inserted, which in turn may reduce the risk of infection and line-related complications;

- Continuous audit of intravenous fluid use in the Integrated Critical Care Unit (ICCU) has led to a reduction in colloid (special fluids) use with a cumulative saving of £89,000 and no associated adverse events;
- The Emergency Department has shown a reduction in the number of attendances of the most frequent service users following the appointment of a care navigator to facilitate assertive outreach by the hospital alcohol team. Weekly multidisciplinary meetings involving social services, community alcohol teams and voluntary sector organisations are held to review attendance patterns and help identify and provide appropriate support to these individuals; and
- To improve discharge planning for children with asthma, the paediatric wards have created an asthma checklist which is completed on discharge and is based upon national 'best practice' standards for managing acute wheezing and asthma.

Participation in clinical research

City Hospitals Sunderland recognises the importance of research in helping the NHS to improve both the quality of care and future health of the nation and in line with Department of Health national strategy is committed to supporting high quality research. Research and development is an amalgamation of a complex group of stakeholders, predominantly led by the National Institute for Health Research (NIHR).The objectives of the NIHR include:

- increasing research activity;
- doubling the number of patients recruited into studies over a five year period (2009/10-2013/14);
- strengthening industry collaboration by increasing the number of commercial studies on the NIHR portfolio,;
- streamlining the approvals system, improving sign off times, and recruitment; and
- improving integration of research into clinical care.

A strong research culture is embedded in the Trust. We have developed close working relationships with the Topic Specific Networks including Stroke, Diabetes, Cancer, Neurodegenerative Disorders and Primary Care Research Networks together with the Comprehensive Local Research Network. In collaboration with network colleagues we actively seek to attract new research into the Trust thus widening the choice of studies available to patients. Cross cover arrangements between the generic nursing team and the networks provides more scope to deliver trials.

Participation in clinical research demonstrates the commitment of City Hospitals Sunderland to improving the quality of care we offer and active participation in research widens the choice and scope of studies. City Hospitals Sunderland involvement in NIHR portfolio studies continues to increase year on year. Recruitment into studies in City Hospitals Sunderland has increased from 740 (March 2011) to 1238 (March 2012).This figure equates to 9% of the Northumberland Tyne and Wear Comprehensive Local Research Networks total recruitment into NIHR portfolio studies for 2011/2012.

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

There are currently 185 studies registered at City Hospitals Sunderland, of which 4 are commercial. City Hospitals Sunderland has a well balanced portfolio across specialties offering patients the opportunity to participate in trials using the latest medical treatments and techniques.

Information on the use of the CQUIN framework

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of the hospital's income to the achievement of local quality improvement goals.

A proportion of City Hospitals Sunderland income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between City Hospitals Sunderland and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKfile.php?id=3275

For 2011/12, approximately £4.7m of income (£3.5m in 2010/11) was attached to the delivery of quality improvements through the CQUIN framework. The Trust achieved the majority of these goals.

The full CQUIN scheme 2011/12 and where we have achieved our targets are highlighted overleaf.

No.	Description of Goal	Indicator	Priority	Weighting	Achievement of target
1	Reducing harm from Venous Thromboembolism(VTE)			10	
1a		% of all adult inpatients who have had VTE risk assessment on admission to hospital, using the clinical criteria of the national tool	National	3	
1b		Proportion of patients assessed to be at increased risk of VTE who are offered VTE prophylaxis in accordance with NICE guidance		3	
1c		Proportion of patients/carers who are offered verbal and written information on VTE prevention as part of the admission process (NICE VTE quality standards)		1	
1d		i) Proportion of all adult inpatients discharged then readmitted within 90 days for pulmonary embolism (PE)		0	
		ii) Identification of patients readmitted with PE and completion of root cause analysis to identify learning and implement appropriate improvements		3	
2	Improving patient experience			10	
2a		Composite measure "Improving responsiveness to personal needs of patients" from the adult inpatient survey (Goal 70)	National	2	
2b		Identified areas for improvement not covered by the adult inpatient survey – paediatrics	Local	4	
2c		Implementation of action plan following inpatient or outpatient survey results CHS - food		4	
3	Effective management of long term conditions (LTC) to improve patient outcomes and minimise readmissions			20	
3a		Proportion of eligible stroke patients that receive all nine indicators from the bundle of care, as defined in the sentinel stroke audit	Local	8	
3bi		% of patients receiving all 4 indicators from the heart failure bundle (set of interventions that, when used together, significantly improve patient outcomes)		3	
3bii		% of patients receiving all 7 indicators from the heart failure bundle		1	
3c		COPD - Joint discharge planning with community teams to reduce repeat emergency attendances.		8	
4	Reduction in harm from pressure ulcers			10	
4a		Reduce number of grade 2 and above hospital acquired pressure ulcers (rate by bed days)	Local	5	
4b		Reduce number of pressure ulcers that deteriorate		5	
5	Reduce harm from falls			10	
5a		% of adult inpatients with falls high risk score that have a documented action plan	Local	3	
5b		Review current arrangements (including data collection/coding) for care provided to patients attending A&E following a fall and develop and implement an improvement plan		7	
6	To support mothers to initiate and continue breastfeeding			5	
6a		Proportion of women that initiate breastfeeding following birth		2	
6b		Proportion of women who initiate breastfeeding following birth and continue until discharge from midwifery care	Local	3	
7	To use preassessment as a health improvement opportunity with patients that smoke			5	
7a		Proportion of patients who have attended preassessment appointment with smoking status recorded		2	
7b		Proportion of patients who have attended preassessment appointment recorded as smokers who have received a brief intervention		3	
8	To improve the standard of end of life care for patients in an acute setting			10	

No.	Description of Goal	Indicator	Priority	Weighting	Achievement of target
8a		Number of patients on the Liverpool Care Pathway as a proportion of those expected to die	Local	2	
8b		Implementation of an improvement plan in one specialty that includes	Local	8	
		Proportion of staff competent in using the Advance Care Plan			
		Percentage of eligible patients offered an Advance Care Plan discussion			
		Percentage of eligible patients where offer of Advance Care Plan has been reviewed			
		Completion of Advanced Care Plan documentation			
9	To improve productivity, clinical effectiveness and patient experience through pathway reform			15	
9a		Introduction one stop care in one cancer service (breast)	Local	7.5	
9b		Planned care - Implementation of the enhanced recovery model of care, in one area to reduce length of stay (colorectal)		7.5	
10	To improve experience of patients with learning disabilities			5	
10a		Improvement in the coding and flagging systems for people with learning disabilities and implementation of regional learning disability care pathways		5	

Amber indicates two quarters or less, out of four not being achieved

Information relating to registration with the Care Quality Commission and periodic / special reviews

City Hospitals Sunderland NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

City Hospitals Sunderland NHS Foundation Trust has participated in a special review of the termination of pregnancy service. As yet no formal report has been received from the Care Quality Commission however immediate action has been taken to address the quality of record keeping within this service.

The Care Quality Commission has not taken enforcement action against City Hospitals Sunderland NHS Foundation Trust during 2011/12.

City Hospitals Sunderland NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Care Quality Commission – Review of Compliance (December 2011)

By law, providers of certain health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care. The Care Quality Commission carried out a routine unannounced review visit in November 2011, when CQC inspectors visited the out-patient departments, the medical admissions unit, and surgical and medical wards. They spoke with patients and their visitors about their experiences of the hospital and the service they had received. In addition, they also spoke with staff and observed how patients were cared for and how staff undertook their day to day duties. The review was supported by an expert-by-experience; a person who has personal experience of using or caring for someone who uses this type of care service.

In their report the CQC stated that City Hospitals were meeting all the essential standards; they found no concerns or requirement for further regulatory action or improvement plans. This is an excellent endorsement of the care provided by City Hospitals in ensuring that the essential standards of quality and safety are being met. The summary statements for each of the five standards reviewed are highlighted below.

Standards which were checked	Standards being met
Standards of treating people with respect and involving them in their care	✔
Standards of providing care, treatment & support which meets people's needs	✔
Standards of caring for people safely & protecting them from harm	✔
Standards of staffing	✔
Standards of management	✔

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

> Overall, we found that Sunderland Royal Hospital was meeting this essential standard. People were supported in a way that maintained their privacy and dignity taking into account their diversity and they were encouraged where possible to make decisions about how they received their care.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

> Overall, we found that Sunderland Royal Hospital was meeting this essential standard. We found that an individualised approach was taken towards the planned care for patients using this service.

Outcome 05: Food and drink should meet people's individual dietary needs

> Overall, we found that Sunderland Royal Hospital was meeting this essential standard. The patients were being supported to maintain an adequate food and hydration intake to maintain their wellbeing or to maximise their potential for recovery.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

> Overall, we found that Sunderland Royal Hospital was meeting this essential standard. We found that people who use the services received their care, treatment and support from competent, trained and supervised staff.

OFSTED/Care Quality Commission Visit

During February 2012, OFSTED undertook a review of Safeguarding practice and procedure within Sunderland Local Authority's Children's Services. This involved a separate but integral visit by the Care Quality Commission to City Hospitals in order to examine our Safeguarding arrangements and to ensure that these meet with national standards. The inspector met with the "Looked After" (Fostering and Adoption) team, the Named and Designated Doctors and Nurses as well as other key staff within the Trust.

We await the final written report, but preliminary verbal feedback indicates a "good" rating in respect of our arrangements.

Information on the quality of data

The Trust submitted the following number of records from 01/04/11 up to 31/03/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data:

- Admitted patient care 102,125
- Out patient care 396,242
- Accident and emergency care 88,372

The percentage of records in the published data which included a valid NHS number for each patient was:

- 99.8% for admitted patient care;
- 99.9% for out patient care; and
- 97.8% for accident and emergency care.

The percentage of records in the published data which included the valid General Medical Practice Code for each patient was:

- 100% for admitted patient care;
- 100% for out patient care; and
- 100% for accident and emergency care.

Information Governance Toolkit attainment levels

The Information Governance toolkit is a mechanism whereby all NHS Trusts assess their compliance against national standards such as the Data Protection Act, Freedom of Information Act and other legislation which together with NHS guidance are designed to safeguard patient information and confidentiality.

The final submission of the Toolkit had to be made by the 31 March 2012. City Hospitals Sunderland Information Governance Assessment Report overall score for 2011/12 was 83% and was graded green (satisfactory).

The Trust will be taking the following actions to improve data quality:

- Accident and Emergency – For Accident and Emergency the introduction of new quality standards and the importance of accurate data for Payment by Results require the Trust to focus on improving data quality within A&E. The new quality standards focus on:
  - Overall time in A&E;
  - Time to initial assessment for patients arriving by ambulance;
  - Time to treatment from arrival;
  - % of patients who left the department without being seen; and
  - % of patients who re-attend A&E (unplanned) within 7 days of original attendance

The Trust's Data Quality Department is working with the A&E team to improve the recording of key data to improve the accuracy of the indicators outlined previously.

- Small Systems - The Trust has recently expanded the Data Quality Policy to include departmental small systems (those areas that do not use the hospitals main system – HISS). A key area of work for 2012/13 is now under way and analysts are reviewing the accuracy of the data held in these systems. A programme of checks and audits has been set up and the objective is to improve the accuracy of data held within them if required.

Clinical coding error rate

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes which reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

City Hospitals Sunderland was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was; 5.4% (diagnosis) and 5.7% (treatment).

It is important to state that the clinical coding error rate is derived from a sample of patient notes taken from selected service areas. The results should not be extrapolated further than the actual sample audited.

An action plan to improve the accuracy of coding has been agreed and will be monitored by the Trust and Sunderland Teaching Primary Care Trust in South of Tyne and Wear PCT Cluster.

Part 3:
Other Information - Review of Quality Performance 2011/12

During 2011/12 we agreed to measure, monitor and report a limited number of key indicators selected by the Board in consultation with key stakeholders, in each of the dimensions of quality; a) patient safety, b) clinical effectiveness and c) patient experience. For each indicator we have included additional comments around our performance and achievements.

a) Patient safety					
Description of Goal	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
1. To reduce mortality rates using CHKS Risk Adjusted Mortality Index (RAMI)	81	84	82	80	84

Mortality rates are a key but complex measure of a hospital's performance. There are a number of ways to measure mortality that take account of factors such as the health of the local community, the age and sex of patients, their primary diagnosis and complicating factors, and their length of stay in hospital. Further analysis of our mortality figures using the new national mortality score (Summary Hospital-level Mortality Index or SHMI) is included within Part 3.

Description of Goal	09/10	10/11	11/12*
2a. Reduce the number of grade 3 pressure ulcers	308	227	53[1] 232[2]
2b. Reduce the number of grade 4 pressure ulcers	130	123	22[1] 126[2]

[1] Hospital acquired
[2] Community acquired
* As of the 1st April 2011 the timescale for classification of community acquired pressure ulcers became the development of pressure damage within 72hrs of admission. This is in line with the NHS Institute for Innovation and Improvement publication 'High impact Action: Your skin matters', the development of nurse sensitive outcome indicators for NHS commissioned care and alignment with our healthcare colleagues within South of Tyne and Wear (SOTW). Prior to this date community acquired was within 24 hours.

During 2011/12 we have specifically increased provision of staff training and education on pressure ulcer risk assessment, grading and management, i.e. Tissue Viability Study Days, HCA Level 2 Development sessions etc. This raised awareness among staff may account, in part, to the increase in grade 3 and 4 pressure ulcer reporting. We have discussed this issue with our commissioners and a re-basing exercise this year will help us set more accurate targets for performance monitoring.

Description of Goal	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
3. Improve the timeliness of discharge communication between the Trust and Primary Care* (2011/12)	73.03%	83.57%	86.79%	82.62%	81.75%	83.50%	77.03%	83.22%

* refers to those completed electronically. The Trust has historically had variable timeliness issues with discharge letters.
Data source: Medisec E-discharge systems and the figures are derived using local specifications.

A new electronic discharge solution was successfully piloted in 2011 and the use of e-discharge letters, in a standard format was rolled out across the Trust. The new letters include clearly documented changes in medication and clear follow up guidance for primary care. Measurement of the new system began in August and information to date shows significant improvements in the quality and timeliness of discharge letters for GPs.

Description of Goal	09/10	10/11	11/12*
4. Preventing occurrence of any 'Never Events'*	N/A	N/A	4

* NPSA definition - are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The underlying principle for the introduction of never events was to ensure that organisations report and learn from serious incidents and strengthen the systems for prevention in the future. City Hospitals has declared 4 never events in 2011/12; one an issue of patient misidentification, two related to retained swabs post operation and one associated with blood transfusion. Any never event report is escalated via our serious incident process and subjected to a root cause analysis (RCA) investigation, so that learning is identified and shared appropriately. In all cases the patient did not come to any significant harm.

b) Clinical Effectiveness						
Description of Goal	**Indicator**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
1. To reduce the number of COPD readmissions*	28 days 30 days	18.85% 19.11%	23.32% 23.96%	23.87% 25.11%	25.68% 26.77%	22.40% 21.06%

* COPD Readmission data based on HRG codes: D39/ D40 – COPD or Bronchitis, with and without complications, readmissions at 30 and 28 days (governed by standard national definitions)

Patients with chronic chest complaints account for a significant percentage of admissions to hospital; the evidence suggests that some of these patients could be avoided and more appropriately managed in the community and at home. Where possible we have tried to reduce readmission rates to the lowest possible level for this important group of patients.

Description of Goal	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
2. Improve internal reporting times for x-ray and ultrasound scans – (exam to report average in days)												
CT Scans	9.95	17.04	12.46	5.78	3.95	3.94	5.07	5.73	4.17	4.91	8.07	5.00
GP X-rays	2.27	3.96	4.47	0.97	1.33	1.43	3.29	1.54	1.51	1.75	3.02	1.24
Hospital X-rays	9.18	8.32	20.06	13.63	5.59	4.23	8.88	7.34	6.81	7.08	7.24	5.88
MRI Scans	19.59	31.91	23.86	16.16	10.67	9.83	16.81	13.89	14.18	13.01	20.70	15.19

Data source: internal radiology data and the figures are derived using local specifications.

The timeliness and reliability of radiology reporting was highlighted as a priority area of improvement for the trust. The aim was to reduce reporting times for plain film x-rays to 2 working days and implement an electronic system for ordering and delivering of reports. Previously the reporting of plain film x-rays took on average 12 days from the image being taken to the signed report being available to the referring GP. Through the adoption of LEAN methodology, the radiology team have internally restructured the way in which the service is delivered. We are pleased to report that over the year we have been able to make significant improvements in radiology reporting times, and this will enhance patient care and treatment.

Description of Goal	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3. Increase the number of patients on the Liverpool Care Pathway as a proportion of those expected to die	33.00	62.29	69.59	86.96	83.33	75.86	75.00	69.70

(High percentage scores show better performance)
Expected deaths defined by local definitions

The Liverpool Care Pathway (LCP) is an integrated care pathway that is used at the bedside to drive up standards of care for patients who are dying and in the last hours and days of life. The LCP affirms the vision of transferring the model of care of the dying from hospice care into other healthcare settings. The Trust has made excellent progress in implementing the LCP with more patients (and their families) than ever receiving the optimal care and support for a compassionate and dignified death.

c) Patient Experience						
Metric	**Description of Goal**	**07**	**08**	**09**	**10**	**11***
Eliminate mixed sex accommodation	Minimising use of same bathroom or shower area for patients of the opposite sex	74	78	79	75	8.7
Communication indicators	Patients involved as much as they wanted to be in decisions about care	71	73	71	74	7.3
	Staff listened to patient concerns and answered questions	80	80	81	82	8.1
	Staff informed patients about medication side effects	47	53	51	52	5.6
	Patients were given all the information they needed for discharge home	56	52	56	58	5.7
Overall satisfaction	How patients rated their overall experience	77	77	77	80	8.0

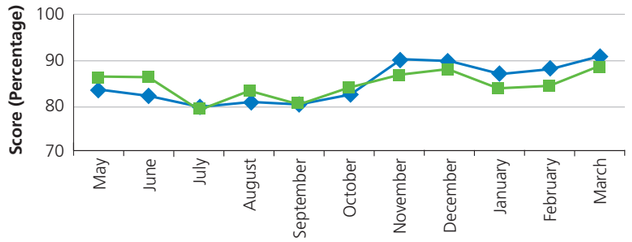
Data source – Annual national inpatient survey programme (2011)
* Survey report has changed; each Trust now receives a score out of 10 for each question

Comments on the patient experience measures

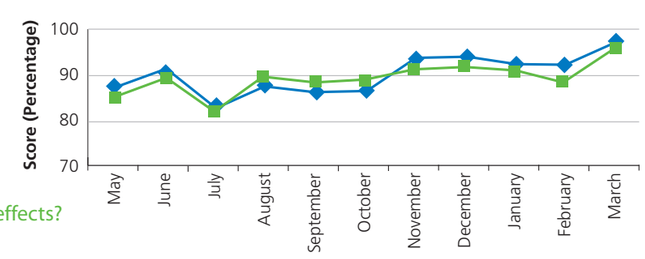
In setting out the priorities for 2011/12 we gave a commitment that we would specifically look to improve the experience of older people around the broad area of communication; a focus requested by Trust Governors and highlighted by the external Local Involvement Network (LINk).

The following tables show the results of communication related questions sourced from our real time feedback survey (May 2011 – March 2012), for those patients aged 70+, against the general average for the Trust. The data points and trend lines show where the older person's experience matches or exceeds the average (for all age groups) in the communication related questions.

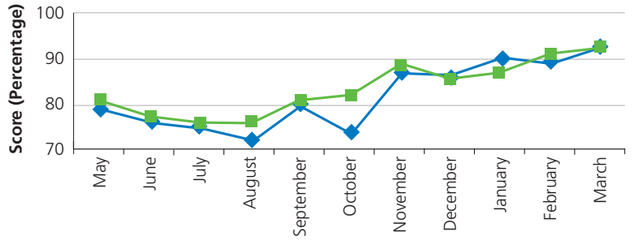
Patients informed and involved in decisions about their care?



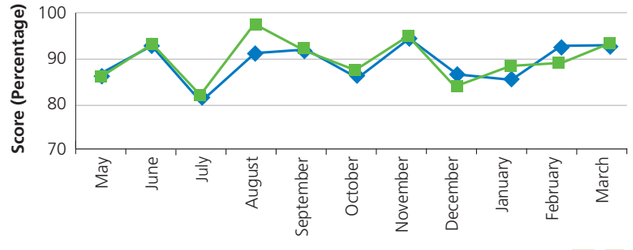
Do staff listen/answer patient concerns and questions?



Do staff inform patients of medication side effects?



Given all discharge information



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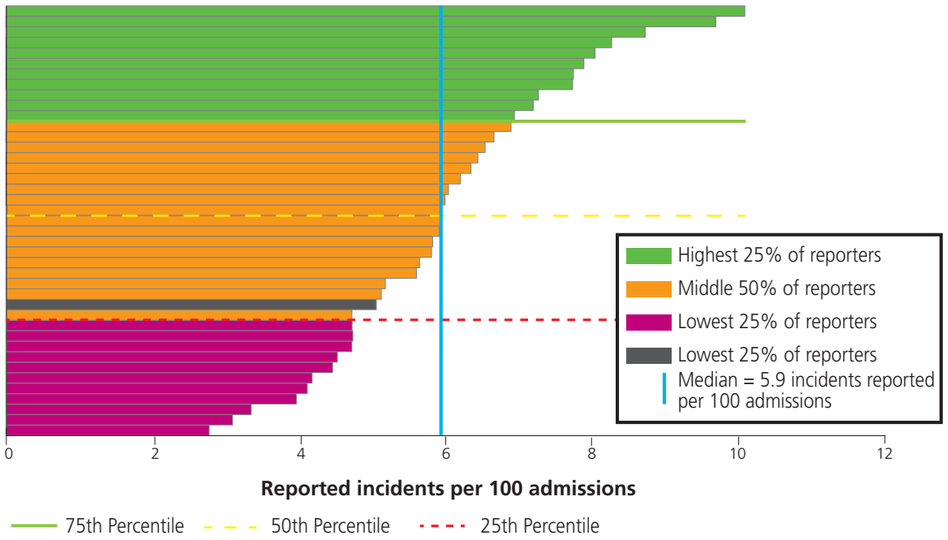
Additional information about our quality improvements

Focusing on Patient Safety

i) Reported patient safety incidents

An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The rate of reported patient safety incidents i.e. unintended or unexpected incidents which could have led, or did lead, to harm for patients, should increase at least in the short term as the reporting culture improves, whilst the numbers of incidents resulting in severe harm or death should reduce. The table below shows the comparative reporting rate, per 100 admissions, for 41 large acute NHS organisations. City Hospitals has a reporting rate of 5.0 incidents per 100 admissions, which is below the 5.9 national average (1 April 2011 to 30 September 2011). Previously the rate was 5.4 (1 October 2010 to 31 March 2011) to 5.2 (1 April 2010 to 30 September 2010).



Source – NPSA Organisation Patient Safety Incident Report (1 April 2011 to 30 September 2011)

When looking at incidents reported by degree of 'severe harm' and 'death' we have experienced our lowest levels within the latest reporting period.

Incidents reported by degree of	Severe harm	Death
1 April 2011 to 30 September 2011	33	8
1 October 2010 to 31 March 2011	57	10
1 April 2010 to 30 September 2010	47	8

ii) Patient Safety First - 'A taste of patient safety'

On 23 January 2012 the National Patient Safety Agency (NPSA) and Patient Safety First hosted a week focusing on nutrition and hydration: 'A taste of patient safety'. City Hospitals played a full and active part in the national initiative and during the week held a series of interactive sessions and activities designed to support patient safety improvement around nutrition and hydration. Some of the activities included;

- Displays of the food and nutritional supplements we provide for patients where patients, visitors and staff stopped and tasted sample menus. The displays were held in the main foyer during the week and staffed by the Catering Team and Dietetic Department staff,
- Informative tours of the Catering Department to experience the meals service 'in action',
- Promotion of new tools to support patient care, including launch of the new beverage trolleys and a series of patient information posters,
- Ward level audits of food and drink provision to patients to help identify areas for further improvement,
- The Trust Executive Team, working alongside ward staff, helped to serve patients their meals during the week and talked to them about their mealtime experience.

ii) Patient Safety First - 'A taste of patient safety'

The Trust has recently introduced a Rapid Incident Review Group to look at all reported serious incidents and to make recommendations on what actions need to be taken.

Some incidents have been selected for wider sharing of learning across the organisation. We have introduced High Impact Safety Messages to either highlight immediate action – "stop the line" – or draw attention to incidents to encourage staff to reflect and change practice. The first two safety messages highlighted:

- The death of a patient following traumatic catheterisation; and
- The need to have systems in place to identify patients with an unexpected diagnosis of cancer and acting on the results.

Focusing on Clinical Effectiveness

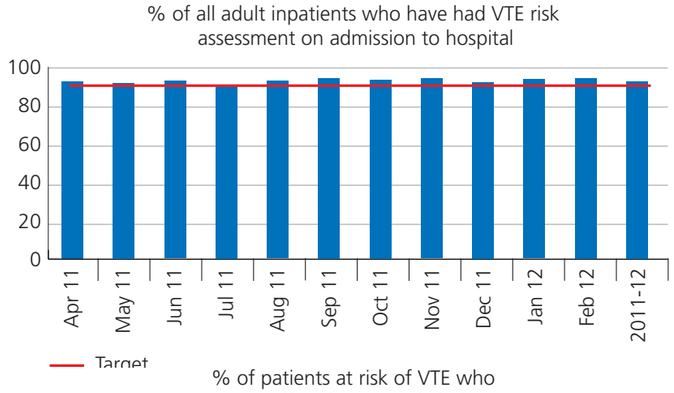
i) Venous Thromboembolism (VTE)

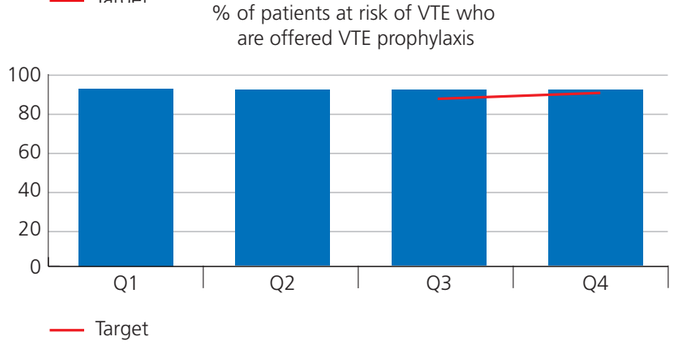
Venous Thromboembolism (VTE) or formation of a blood clot is a condition that can cause a significant number of deaths each year, many of which could be avoided. In 2010 a number of measures were introduced across the NHS to help ensure that every adult patient had a documented VTE risk assessment on admission to hospital.

We reported last year that the Trust had introduced a new electronic assessment form that enabled us to achieve the national target of over 90% of patients receiving a VTE risk assessment. We have consolidated this position and during 2011/12 we also measured whether those patients assessed as 'at risk' were given the appropriate treatment in line with NICE guidance. This was included in our CQUIN scheme this year. Regular monitoring of 'at risk' assessment shows an increasing proportion of patients being prescribed VTE prophylaxis (a measure taken to prevent blood clots) in accordance with national standards.

Indicator	Q1	Q2	Q3	Q4
Reducing harm from VTE				
% of all adult inpatients who have had VTE risk assessment on admission to hospital, using the clinical criteria of the national tool (target is 90%)	91.53%	91.92%	92.90%	92.12%
Proportion of patients assessed to be at increased risk of VTE who are offered VTE prophylaxis in accordance with NICE guidance	75.81%	88.16%	92.31%	90.16%

(Governed by standard national definitions)





Data source: internal inpatient data and the figures are derived using standard national definitions

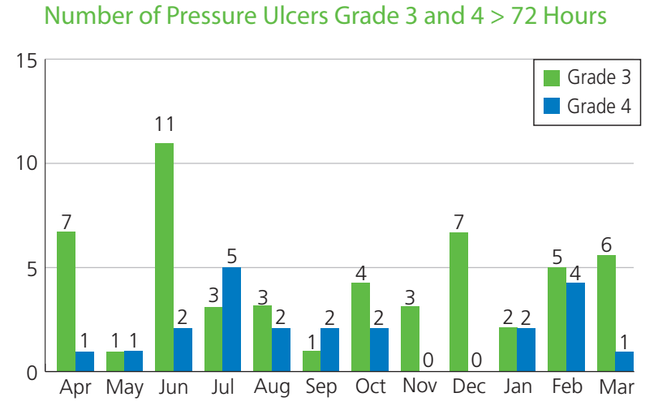
ii) Pressure ulcers – reducing the incidence of hospital acquired pressure ulcers

Pressure ulcers represent a major burden of ill health and reduced quality of life for patients, their carers and families. During 2011/12 the Trust has continued to prioritise this area of clinical practice and we had two related targets in our CQUIN scheme; to reduce both the number of Grade 2 and above hospital acquired pressure ulcers and reduce pressure ulcers that deteriorate.

The Tissue Viability Group (incorporating pressure ulcers) has been instrumental in improving our assessment and management practices. Our Trust policy has been revised and updated and staff have had access to various training and education sessions, supported by regular newsletters. In addition, root cause analysis investigations (RCA) have been undertaken for any grade 3 and 4 pressure ulcer (the more serious ulcers) to ensure that we take the right steps to improve their prevention and treatment and share the learning with other areas in the Trust.

Next year we will be participating in the national 'NHS Safety Thermometer' programme which provides a 'temperature check' on how we risk assess and manage pressure ulcers; this is an important aspect of our aim to eliminate avoidable ulcers and promote 'harm-free' care.

The table below shows our performance over the year i.e. the number of grade 3 and grade 4 hospital acquired pressure ulcers.



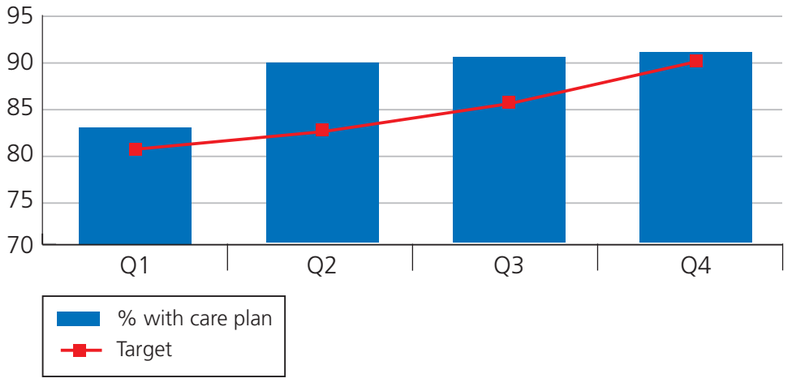
Highest Grade	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
3	7	1	11	3	3	1	4	3	7	2	5	6	**53**
4	1	1	2	5	2	2	2	0	0	2	4	1	**22**
Total	**8**	**2**	**13**	**8**	**5**	**3**	**6**	**3**	**7**	**4**	**9**	**7**	**75**

The Trust has an action plan in place to improve the prevention, risk assessment and management of pressure ulcers, which is overseen by the Tissue Viability Group. Some of the developments we have made or are currently working on include:

- Invigoration of the Tissue Viability Link nurses' roles and responsibilities;
- Tissue Viability Link sessions are bi-monthly disseminating updates;
- Introduction of Tissue Viability Study Days – a two day programme which is supported by various City Hospitals staff members as key speakers;
- An e-learning educational package has been identified and will be made available to all staff shortly;
- Our Health Care Assistant Level 2 development sessions now include pressure ulcer management information;
- Care of pressure ulcers 'aide memoires' have been produced and are to be distributed to all ward work stations for access by the whole healthcare team;
- A Trust-wide tissue viability newsletter is produced quarterly;
- A new tissue viability patient information leaflet will be available to all wards.

iii) Falls prevention and management

The prevention of patient falls has been a key priority for the Trust for some time and our Hospital-Based Falls Group have reported encouraging improvements in their actual reduction and associated injury. In addition, as part of the CQUIN scheme the Trust monitors the number of patients who receive a Falls Risk Assessment and have a score of 15 or more to establish whether a care plan is put in place. The table below shows sustained high performance during the year:



(Governed by regional definitions)

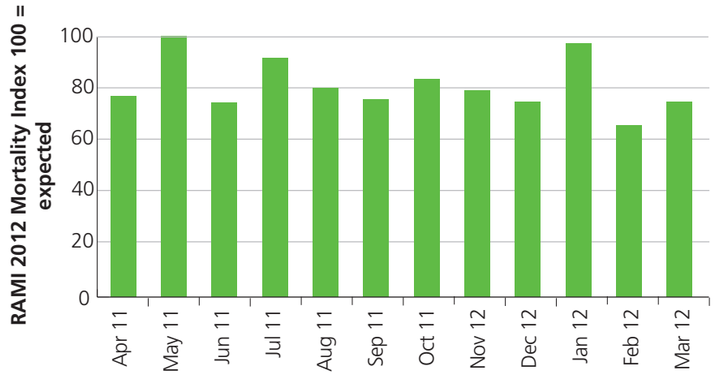
The Hospital Based Falls Group is now well established in the Trust with a focused work plan, including:

- Measuring and monitoring of the CQUIN target, 'percentage of patients over the age of 65 attending A&E with fall/blackout or fracture resulting from a fall';
- Revising and updating the 'Prevention and Management of Hospital Based Patient Falls Policy' in line with best practice; and
- Consolidation of the Falls link-staff sessions that are held bi-monthly and which provide an essential information exchange within the hospital.

iv) Mortality

Mortality rates are a key measure of a hospital's performance on clinical outcomes. There are now a number of ways to measure and understand mortality. The Trust uses the CHKS (Caspe Healthcare Knowledge Systems) tool to standardise mortality measurement and produce a mortality indicator. This indicator is known as the Risk Adjusted Mortality Index (RAMI). It is a complex indicator which is reviewed annually after a new base line is set. Standardisation of mortality rates allows comparison between different hospitals serving different communities. This indicator takes account of factors such as the health of the local population, the age and sex of patients, their primary diagnosis and complicating factors, and their length of stay in hospital.

If the Trust has RAMI of 100, this means that the number of patients who died is exactly as would be expected. A Trust RAMI above 100 means that more patients died than would be expected; and below 100 means that fewer patients than expected died. It is not an absolute indicator of the quality of care and should not be used in isolation. In last year's Quality Report we showed that our RAMI score was consistently better than the national average. That trend has continued during 2011/12 even after the annual RAMI re-basing exercise undertaken by CHKS:



(Governed by CHKS definitions)

On the 27 October 2011 the new Summary Hospital-level Mortality Index (SHMI) was published by the NHS Information Centre. The indicator provides a common standard and transparent methodology for reporting mortality at Trust level. The NHS now has a number of different ways to measure mortality, which can be confusing, but their purpose is consistent, to help identify any trends in mortality which require further investigation.

One SHMI value is calculated for each Trust. A Trust's SHMI value is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated.

The baseline SHMI value is 1. A Trust would only get a SHMI value of 1 if the number of patients who die following treatment there was exactly the same as the number expected using the SHMI methodology.

To order to understand the SHMI values, they are categorised into one of the following three bandings:

- Band 1 – where the Trust's mortality rate is 'higher than expected'
- Band 2 – where the Trust's mortality rate is 'as expected'
- Band 3 – where the Trust's mortality rate is 'lower than expected'

The three SHMI publications to date show that City Hospitals has 'as expected' mortality; the majority of NHS Trusts are banded at this level.

Indicator	Apr 10-Mar 11	Jun 10-May 11	Oct 10-Sep 11
SHMI value	1.0693	1.0166	0.987
SHMI banding	Band 2 **'as expected'**	Band 2 **'as expected'**	Band 2 **'as expected'**
% of patients admitted to the Trust whose treatment included palliative care	0.7	0.8	0.8*
% of patients admitted to the Trust whose deaths were included in SHMI and whose treatment included palliative care	11.1	12.5	13**

* National average is 0.9% ** National average is 16%
Governed by standard national definitions

Palliative care (an approach that improves the quality of life of patients and their families facing life-threatening illness) has a potential impact on hospital mortality. The SHMI makes no adjustments for palliative care coding (unlike some other measures of mortality), so all patients who die are included. The palliative care coding measures in the table are moving towards the national average.

The Dr Foster report 'Inside Your Hospital' (Nov 2011) also highlighted **'as expected'** trust performance for four important measures of mortality; Hospital Standardised Mortality Ratio (HSMR), SHMI, deaths after surgery, and deaths in low-risk conditions.

Focusing on Patient Experience

i) The NHS Adult Inpatient Survey 2011

Once again we fully participated in the national adult inpatient survey, inviting patients to give their views on the service they received from City Hospitals. It remains one of the largest surveys of patient experience in hospital of its kind. The questionnaire asks patients to comment on topics ranging from hospital food, cleanliness, privacy and dignity, to communication with staff, discharge planning and overall quality of care. Questionnaires were posted to 850 people and 479 were returned complete; giving a response rate of 57% (the national rate was 53%).

For 2011 a new style of report was produced for the national survey which aligns the results to those presented on the Care Quality Commission website, making it easier for the public to identify how well their local Trust did in the survey, when compared with the performance of other Trusts.

Each Trust receives a score out of 10 for each question (previously it was 100). A higher score is better. Each Trust is also assigned a category, to identify whether their score is 'better', 'about the same', or 'worse' than most other Trusts who carried out the survey.

The results for City Hospitals across the main survey themes are highlighted below (governed by national standard definitions):

Based on patients' responses to the survey, this trust scored		How this score compares with other trusts		
8.0 / 10	The emergency / A&E department, answered by emergency patients only	WORSE	ABOUT THE SAME	BETTER
6.6 / 10	Waiting lists and planned admissions, answered by those referred to hospital	WORSE	ABOUT THE SAME	BETTER
8.4 / 10	Waiting to get to a bed on a ward	WORSE	ABOUT THE SAME	BETTER
8.2 / 10	The hospital and ward	WORSE	ABOUT THE SAME	BETTER
8.7 / 10	Doctors	WORSE	ABOUT THE SAME	BETTER
8.4 / 10	Nurses	WORSE	ABOUT THE SAME	BETTER
7.6 / 10	Care and treatment	WORSE	ABOUT THE SAME	BETTER
8.5 / 10	Operations and procedures, answered by patients who had an operation or procedure	WORSE	ABOUT THE SAME	BETTER
7.4 / 10	Leaving hospital	WORSE	ABOUT THE SAME	BETTER
6.3 / 10	Overall views and experiences	WORSE	ABOUT THE SAME	BETTER

From the more detailed results, the survey shows that across the 64 questions which measure our performance from the patients perspective, 63 (98.5%) are in the amber 'expected range' category meaning that we are about the same as most other Trusts in the survey. One question is in the green category meaning that we scored 'better' than the majority of trusts. We have no questions in the red or 'worse' category.

For the last few years the Trust has been highlighted as 'red' or performing in the worst 20% of Trusts category for questions around hospital food and management of the patient's pain. Our results for 2011 are encouraging in these areas and show that we have achieved an 'expected range' or amber score for both, however we will continue to retain these as our top priorities for enhancing the patient experience.

The tables below show where the Trust has achieved the largest increase and decrease in scores compared to the last survey in 2010. In view of the redesign of the reports we are not able to meaningfully compare performance against earlier surveys (the Care Quality Commission has applied a statistical test to the 2010 data making it amenable to comparison; this is not provided for surveys pre-2010).

Survey questions – comparison of 2010 and 2011 results		2010	2011	
Largest increase in scores				
Q19	Did you ever use the same bathroom or shower area as patients of the opposite sex?	7.5	8.7	▲
Q71	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	5.7	6.5	▲
Q44	Did you find someone on the hospital staff to talk to about your worries and fears?	5.8	6.4	▲
Q59	Did you feel you were involved in decisions about your discharge from hospital?	7.1	7.6	▲
Q30	Did you get enough help from staff to eat your meals?	7.3	7.7	▲
Q46	Were you given enough privacy when discussing your condition or treatment?	7.9	8.3	▲
Q63	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	6.9	7.3	▲
Q65	Did a member of staff tell you about medication side effects to watch for when you went home?	5.2	5.6	▲

(Governed by national standard definitions)

Survey questions – comparison of 2010 and 2011 results		2010	2011	
Greatest loss in scores				
Q5	Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?	6.8	6.4	▼
Q20	Were you ever bothered by noise at night from other patients?	6.7	6.3	▼
Q61	Discharge delayed due to wait for medicines/to see doctor/for ambulance	7.5	7.1	▼

We will be working to address these issues. We have already highlighted in Part 1 of this report (under Priority 2: Patient Experience) improvements in our priorities around hospital food and management of pain.

ii) The NHS Outpatient Department Survey 2011

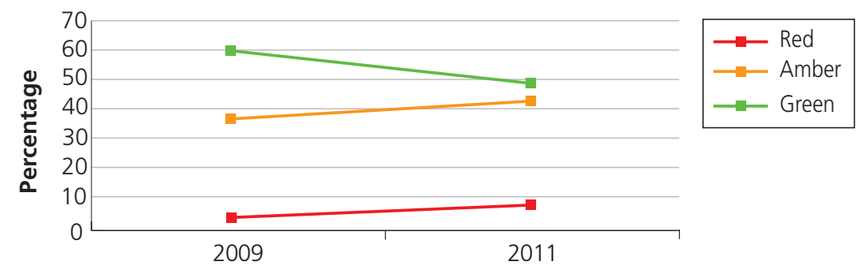
All NHS Trusts in England are required to carry out local surveys asking patients for views on their recent healthcare experience. Nationally, over 72,000 people who attended outpatient departments in April or May 2011 completed the survey which involved 163 acute and specialist NHS Trusts. City Hospitals had 484 patient questionnaires returned for analysis and a response rate of 57% (nationally 53%).

The Outpatient Department survey results are collated nationally and contribute to the Care Quality Commission's assessment of Trust performance against the essential standards of quality and safety.

The tables below show the distribution of scores compared with the last outpatient department survey undertaken in 2009; the proportion of scores in the highest (green) category has fallen from 60% to 49% and those in the lowest (red) have increased slightly from 3% to 8%.

Distribution of category ratings for surveys 2009 & 2011

Trends of category ratings for surveys 2009 & 2011



Did we do any better than last time?

Survey questions		2009	2011	Change
Before the appointment				
Q5	Were you given a choice of appointment times?	60	74	▲
Q7	Before your appointment, did you know what would happen to you during the appointment?	62	67	▲
Hospital environment and facilities				
Q10	In your opinion, how clean was the Outpatients Department?	89	90	▲
Q11	How clean were the toilets at the Outpatients Department?	88	89	▲
Tests and treatment				
Q13	Did a member of staff explain why you needed these test(s) in a way you could understand?	85	86	▲
Q14	Did a member of staff tell you how you would find out the results of your test(s)?	87	88	▲
Q15	Did a member of staff explain the results of the tests in a way you could understand?	77	78	▲
Q22	Did the doctor explain the reasons for any treatment or action in a way that you could understand?	88	89	▲
Q23	Did the doctor listen to what you had to say?	91	92	▲
Seeing a doctor				
Q24	If you had important questions to ask the doctor, did you get answers that you could understand?	82	84	▲
Seeing another professional				
Q28	If you had important questions to ask him/her, did you get answers that you could understand?	86	89	▲
Q29	Did you have confidence and trust in him/her?	92	93	▲
Overall about the appointment				
Q33	How much information about your condition or treatment was given to you?	89	91	▲
Leaving the outpatients department				
Q46	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	58	68	▲
Overall impression				
Q51	Overall, how would you rate the care you received at the Outpatients Department?	85	86	▲

(Governed by national standard definitions)

Across the main survey themes the Trust has improved its performance, as reported by patients, in areas such as choice of appointment times, waiting times, cleanliness, explanation of tests and treatments, patients' confidence with the clinical team and patients receiving copies of letters sent between hospital doctors and their GP. Overall patients rated highly the care they received at the Outpatients Department – the Trust achieved a score of 86 which is the threshold for the highest scoring 20% of Trusts.

We know where we need to improve

However, some improvements are required in areas such as explaining to patients about their medication side effects and danger signals to watch for, minimising change of appointment times, and the need for staff to introduce themselves and not to talk in front of patients.

The red scores found in the survey and therefore requiring improvement were:

- Q2 - From the time you were first told you needed an appointment, how long did you wait for your appointment? (score of 83 – threshold for the lowest scoring 20% of Trusts was 83)
- Q6 - Was your appointment changed to a later date by the hospital? (score of 88 – threshold for the lowest scoring 20% of Trusts was 88)
- Q32 - Did doctors and/or other staff talk in front of you as if you weren't there? (score of 91 - threshold for the lowest scoring 20% of Trusts was 91)

The results have been shared with the Outpatient Department Team and we will be working closely with colleagues to address these areas.

What did our patients say?

Positive comments

- "I have always been seen within a reasonable time, and have always been treated with respect and consideration. I have no complaints at all with the NHS and would most likely not been here now without them. Thank you may God bless you all."
- "Doctor very caring and considerate, a perfect gentleman"
- "The two nurses involved in my 'walk test'" were very friendly, informative, made me feel at ease at all times. In my opinion their approach is 'ideal' for people with possible heart problems it was a "stress free" environment they created".
- "Seen on time, very prompt service, wish every visit could be like this".
- "The care and attention was exceedingly good."

Negative comments

- "Time keeping for appointment time. Crowded waiting room. No seats available at first".
- "Parking. I have been to the hospital on numerous occasions and only been able to park in the grounds once. Usually have to park up to a quarter mile away or more."
- "It would be helpful if the appointment letter stated that you would need an x-ray when you arrived".
- "Better directions to departments."
- "Stop changes to appointment dates, a patient get his/her hopes built up that something is at last going to be done to alleviate their condition, but a week before the date their hopes are dashed because of yet another change to their appointment time."

iii) National Survey of Parents' Experience of Neonatal Care 2011

City Hospitals participated in the first national survey of parents' experience of neonatal services. The aim was to assess parents' experiences of neonatal care and to understand how the quality of care could be improved. Nationally, almost 20,000 parents were sent a postal questionnaire following their baby's discharge from hospital asking about their experiences of neonatal care. Over 9,000 parents took part in the survey; City Hospitals received 71 responses and a return rate of 49.3% (nationally 50%).

Parents scored highly their experiences around the initial admission of their baby to the neonatal unit and had confidence and trust in the neonatal staff caring for their baby. Information and support for parents was rated highly, particularly in relation to feeding of their baby.

Experience was less positive around parental involvement and discussions about their baby's condition or care. Lack of privacy and space within the neonatal unit also contributed to a number of red scores*.

* the Neonatal Unit is undergoing refurbishment in 2012

Out of 64 'performance' questions, the Trust received the following scores;

- Red category (scores for the 20% of trusts with the lowest scores) - 9/64 (14%)
- Green category (20% of trusts with the highest scores) - 15/64 (23%)
- Amber category (scores for the remaining 60% of trusts) - 40/64 (63%)

Areas where City Hospitals is in the top 20% of the highest performing Trusts nationally
• Partner/companion were able to speak to a doctor or nurse about their baby's condition as soon as they wanted?
• Infection control practices were explained, such as handwashing
• Mothers were provide with a photograph of their baby
• Enough information was given about the neonatal unit
• Mothers were cared for in a separate room/area to other mothers who had their baby with them
• Staff did keep mothers up to date with their baby's condition and progress
• Mothers were able to talk to staff on the unit about their worries and concerns
• Mothers were able to speak to a doctor as much as they wanted

Areas where further improvements are required
• Mothers didn't have as much 'kangaroo care' (skin-to-skin contact) with their baby as they wanted
• Some mothers felt that doctors and nurses did not always include them in discussions about their baby's care and treatment
• Mothers felt they weren't given enough privacy when discussing their baby's care
• There wasn't enough space for mothers to sit alongside their baby's cot in the unit
• Some mothers felt that staff did not give them enough information about parent support groups

The questionnaire also asked parents to add any further comments about their experiences of neonatal care. These comments were reported verbatim; the majority were highly positive about their overall experience and show great respect and genuine appreciation for neonatal unit staff at City Hospitals. A selected number of comments are highlighted:

> "I would like to thank for all the staff of neonatal care that took care of my baby and myself. Thank you for all the help, care and support for both of us. It was the worst week of my life (in emotional way) when my baby was in neonatal care, but thanks to all nurses and doctors kindness, and professionalism at their job - you made it easier. So once again a really big thank you from all of us."

> "Our experience was extremely positive and I have very fond memories of my son's time, which is a strange, but lovely way to describe it. This was down to the staff and 'feel' of the unit. Due to the sensitive and encouraging nature of the staff I successfully expressed from day 2 and breastfed for 7 days and have continued to do so until 6 months. The staff in the unit were faultless."

> "I could not fault Sunderland Neonatal Unit at all. Everyone involved in my baby's care were absolutely fantastic and they all do a superb job."

> "The care they provided was of the highest quality. They could do with more staff and more facilities so they could care for more babies. During my babies' care they were often on telephone trying to soft out spaces for babies, I heard on occasion them having to transfer babies. Despite this I never felt my child's care was anything less then 100%."

> "I cannot compliment Sunderland NICU enough. They were supportive, helpful, and knowledgeable and treat my baby, my husband and I brilliantly. The level of care is very high and I would not have wished my baby to have been any where else."

The results of the survey have been shared and discussed with the Neonatal Team and an action plan has been agreed to address areas for improvement. The local Neonatal Network has given a commitment to support the implementation of any actions, if required. Our Patient and Public Involvement Committee will ensure that action is taken and progress is maintained in anticipation of a repeat survey in 2012/13.

Being responsive to the personal needs of patients

A composite score of 'responsiveness to the personal needs of patients' was set as part of our CQUIN scheme last year and was measured by calculating scores from five individual survey questions in the 2011 inpatient survey. Results are shown in the table below. We did achieve the improvement target we were aiming for (composite score of 70 out of 100 - the higher the composite score, the better).

The five key responsiveness questions	Score
Were you involved as much as you wanted to be in decisions about your care and treatment?	73.5
Did you find someone on the hospital staff to talk to about your worries and fears?	63.9
Were you given enough privacy when discussing your condition or treatment?	82.5
Did a member of staff tell you about medication side effects to watch for when you went home?	55.6
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	81.4

How we measure up to CQUIN targets		
Composite score	Target	2011
Achieved	70	**71.4**

Staff views on the standards of care

How members of staff rate the care of their local hospital can also be a meaningful indication of the quality of care and a helpful measure of improvement over time. One of the questions asked in the annual NHS Staff Survey includes the following statement: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust" and asks staff whether they strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree.

Our staff have increased their rating of:

Indicator	2010	2011	Average for all Trusts
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust"	57%	59%*	62%

Source – NHS Staff Survey 2011

* Percentage calculated by adding together the staff who agree and the staff who strongly agree with this statement

iv) Real Time Feedback

Real time feedback asks the views of patients about key aspects of their hospital stay. The programme, now into its second year, is well established in the trust and continues to be led by a network of lay groups and volunteers. They visit all participating wards on a monthly basis and invite patients, who are ready to go home, to complete a short questionnaire about their hospital experience. A minimum 10 questionnaires are completed per ward, per month, and wards are expected to feed back the results with their staff and act on the findings, where appropriate. Real Time Feedback started in August 2010 and since then the Trust has received and analysed 4653 patient questionnaires, many of which include additional patient comments.

Where are we doing well?

Top scoring questions			
C6	Do you have somewhere to keep your personal belongings whilst in hospital?	9	99%
C7	Do staff wash their hands before providing your care?	7	97%
C4	Have the staff been polite and professional during your stay?	6	96%
C5	Is the ward clean and tidy?	6	96%
B1	When you were first admitted to a bed on this ward, have you had to share a sleeping area, for example a room or bay, with patients of the opposite sex?	5	95%
C1	Are you treated with privacy, dignity and respect?	5	95%

What do patients want us to improve?

Lowest scoring questions			
C11	Is your food well presented and hot enough?		80%
C12	Are you offered a good choice of food?	8	78%
C10	Do staff inform you about medication side effects?	9	79%

* Each is equivalent to a score of 10

What do patients want us to improve?

Simply collecting feedback from patients by itself has no value. It needs to be used by clinical and management staff to identify aspects of their service that need to improve, so that the team can take appropriate action. The following examples highlight where staff and teams have acted on the findings of patient feedback:

- Choices of meal options have been improved for certain patient groups, i.e. reduced fatty foods for breakfast , fruit offered to patients on the bariatric ward and availability of 'lite bite' menus for patients in emergency assessment units after they have been 'nil by mouth' for scans etc,
- Piloted the Trust RADAR on all surgical wards; essentially this is a practical framework to encourage better pain management practice at local level,
- Introduced an extra hot beverage round in the morning,
- Many wards have purchased larger cups following requests made by patients,
- Some wards are trialling daily real time feedback questionnaires for team discussion to help address issues "on the spot".

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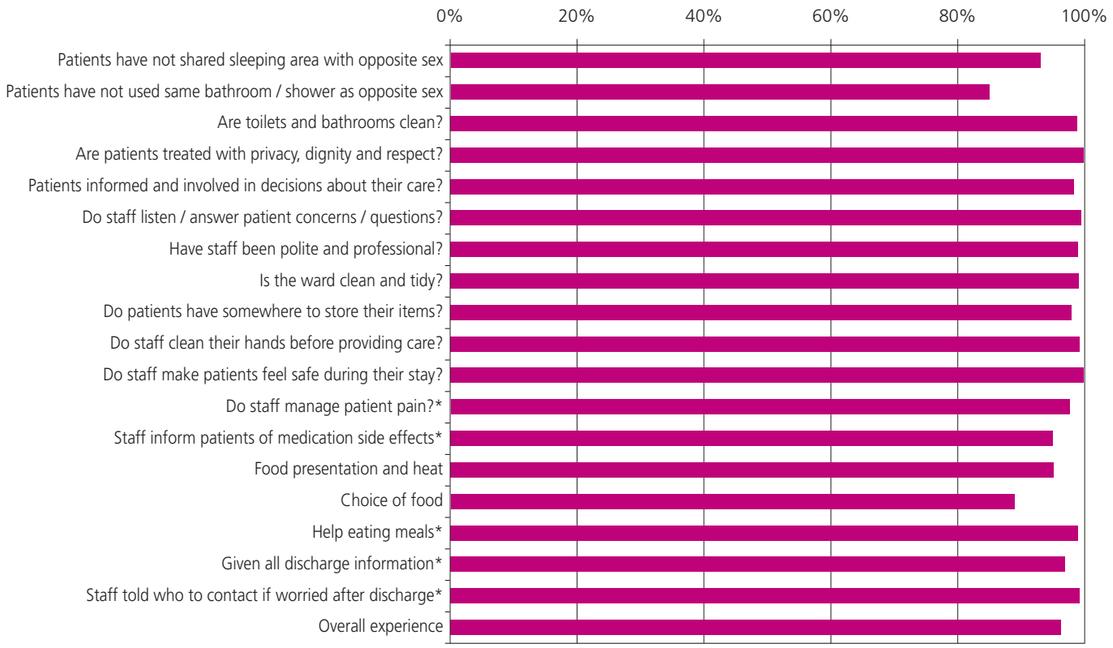
What we said we would do to make improvements to real time feedback

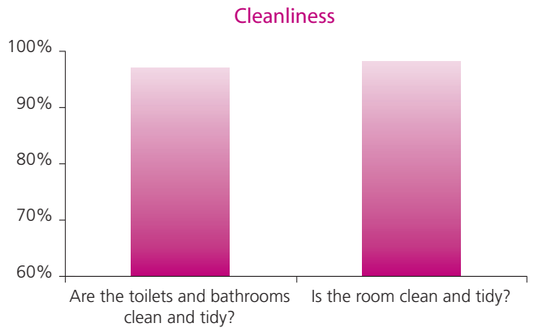
In last year's Quality Report we promised we would expand real time feedback into areas such as maternity, children's wards and the Sunderland Eye Infirmary, where we have customised the 'core' questionnaire. We also said that we would design and showcase posters to show patients and the public that we have listened to their views and made changes to our practices.

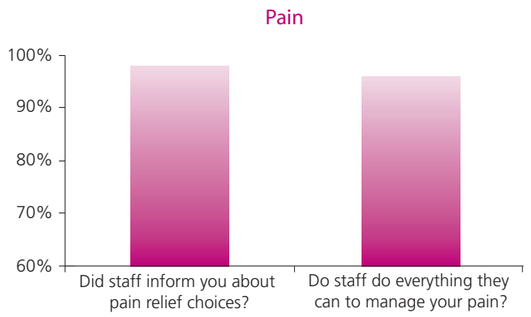
The chart below shows the type of visual performance feedback we provide to all our participating wards each month; this particular chart gives the cumulative position for the Sunderland Eye Infirmary (Haygarth Ward: May 2011 – March 2012) against each question asked in the survey. The higher the score (and position to the right), the better the patient experience.

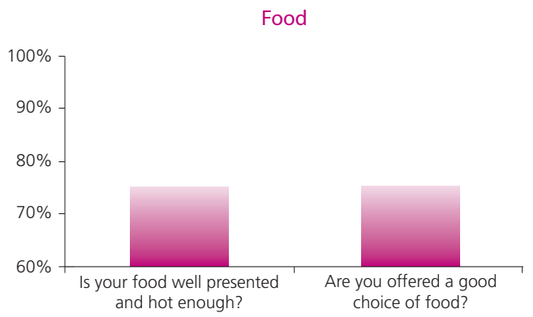


This shows our first real time feedback poster highlighting to patients and their visitors the improvements we have made to hospital meals; these were widely circulated to all wards and departments and made available in reception and public areas. The next poster will show improvements in pain management and will be launched at the Standards of Care Day event in June 2012.

The maternity version of real time feedback started in November 2011 with some changes made to the core questionnaire. Our Chair of the Maternity Services Liaison Committee and Board of Governor member has played a significant part in developing the system for maternity. To date we have surveyed 230 women (with some involvement from their partners) and a sample of results are shown below:







A number of areas to focus on in Maternity include; the offer of home births, partner stays and food options.

Real time feedback has been introduced differently in paediatrics, in consultation with staff; not only are the children asked about their experiences but also their parent's or carer's views are included. Our Nursery Nurses collect the information from the children, adjusting their approach and way of asking the questions according to the child's age, understanding and abilities. The paediatric surveys started in October 2011 and to date we have collected comments and views from 131 children and 171 parents (The parents outnumber the children because some are too young to participate).

Each of the 3 paediatric wards have action plans to address any issues that are highlighted in the surveys, for example, improvement of facilities for parent overnight stays, food provision for youngsters and improving children's perception and understanding of pain.

v) Patient Reported Outcome Measures (PROMS)

Trusts are required to report on patient-reported outcome measures (PROMs). PROMs are used to collect information for elective NHS patients undergoing Hip or Knee replacements, Groin Hernia surgery or Varicose Vein procedures.

PROMS are short, self-completed questionnaires. They measure the patient's health status or health related quality of life at a single point in time. The first questionnaire is given during the patient's preoperative assessment or on the day of admission. A second questionnaire is sent six months from date of surgery. For varicose vein and groin hernia procedures, the survey is sent out three months following surgery.

Source: Quality Health

PROMs provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. These questionnaires can be completed by a patient or individual about themselves, or by others on their behalf.

Information about our PROMS performance across the four elective procedures (hip & knee replacement, varicose veins and hernia surgery) are highlighted below:

PROMS measure	Period	Trust value	National average	Chart (displays variation)
% patients reporting an improvement following hip replacement	April-Sep 2011	100%	87.7%	
% patients reporting an improvement following knee replacement	April-Sep 2011	92.3%	80.3%	
% patients reporting an improvement following varicose vein procedure	April-Sep 2011	47.6%	47.5%	
% patients reporting an improvement following hernia procedure	April-Sep 2011	50.0%	51.0%	

Data source: Acute Trust Quality Dashboard (East Midlands Quality Observatory)
*City Hospitals position is noted by ♦
Governed by standard national definitions

During the period April – Sep 2011, patients reported improvements, in terms of health gain, i.e. levels of mobility, self-care, pain and discomfort and anxiety, in three out of the four procedures; with only hernia surgery very slightly below the national average. The largest health gain can be found in joint surgery, i.e. hip and knee replacement.

We will continue to review the data and to consider how best to use them more actively in our quality monitoring activities.

vi) Your Stay in Hospital Bedside Folder

In September 2011 we introduced the 'Your Stay in Hospital' patient bedside folders which are small ring binders providing core hospital and ward information for patients and their families. They have replaced paper booklets and information sheets, and provide a single, comprehensive source of information about coming into hospital.

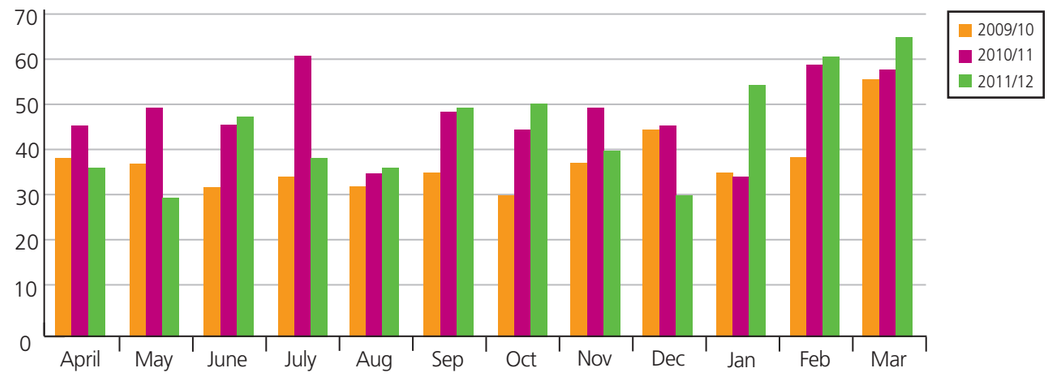
Our Community Panel will be undertaking an evaluation of their accessibility and value to patients and visitors during the Spring 2012. In addition we are also negotiating a contract to review and professionally print our range of bereavement booklets during 2012.

vii) Listening to patients – learning from our complaints

The Trust has a well established complaints process in line with national guidance, which seeks to ensure that patients, carers and visitors concerns are fully and promptly investigated and acted upon, where necessary, to improve services and the patient experience.

During 2011/12 the Trust received 534 formal complaints from patients or their representatives. This represents a 6% decrease compared to last year. The chart below shows the distribution of complaints received each month for the current and previous two years.

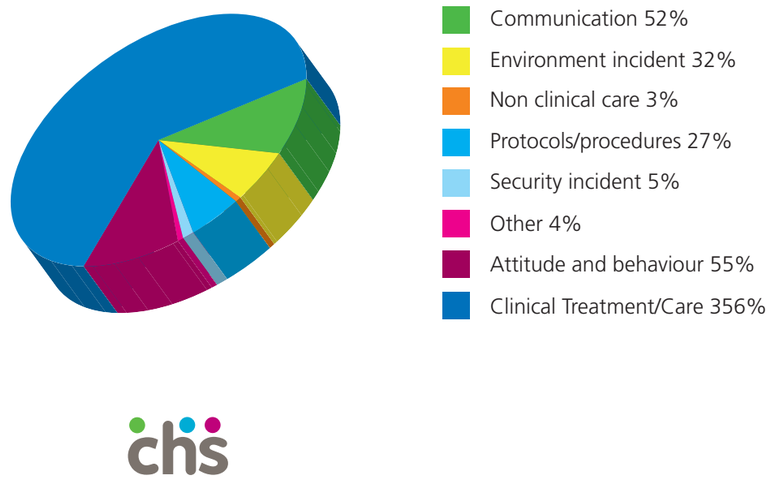
Comparison of complaints activity 2009/10 to 2011/12



Governed by standard national definitions

The chart below shows that the top corporate themed complaints were related to aspects of clinical care and treatment, attitude and behaviour of staff, and communication and environmental incidents.

Complaints activity by corporate theme 2011/12



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What changes have been made in response to patients (and their families) raising concerns?

An important part of our complaints work in the Trust is to understand what went wrong and, where possible, to take action to prevent reoccurrence. The following examples highlight where we have made changes to practice as a result of complaints:

- Introduction of regular "comfort checks" on some wards to ensure regular documented patient checks,
- Colour co-ordinating water jugs to easily identify patients who require assistance,
- Introduction of red trays on all wards to indicate patients who need assistance with feeding,
- Specific infection control guidelines developed for haematology patients,
- Special arrangements in place with radiology to ensure priority investigation and return to ward for some vulnerable patients,
- Recliner chairs bought so that expectant fathers can be more comfortable awaiting the birth of a child,
- Review of clinical guidelines and procedures in a number of areas,
- Redrafting of patient information and appointment letters.

The Patient Advice and Liaison Service (PALS) is an important service in the hospital where patients, relatives and carers can seek advice or raise a concern independently from the ward or service they are attending. The service is impartial and seeks to address concerns as quickly as possible, preferably while the patient is still in hospital.

When asked, some of our patients and staff have told us that they were not aware of the service. As a result, from April 2012, we now have a more visible service in the main reception corridor (Hylton Road Block) where patients, relatives and carers can seek advice. For confidential issues, a separate meeting room is available. PALS advisers will take details and investigate concerns within 24 hours wherever possible to ensure a speedy resolution of issues.

viii) Community Panel

The Community Panel are our lay group of volunteers who continue to play an important part in our commitment to patient and public involvement. This year heralded a significant milestone in the history of the Panel as they celebrated their 10th anniversary. In recognition of this achievement a special award was made to the Community Panel at the Reward & Recognition Event held at the Stadium of Light in October 2011.

The 10th anniversary also coincided with a comprehensive review of the Community Panel designed to 'take stock, reflect, and recommend' a revised model of the Panel that would further strengthen its role in patient and public involvement. The review had the full support and participation of the Panel and one of the key issues in moving forward was to look at new ways to involve and use the experiences of the Panel in a broader range of activities. Whilst the review dominated the work of the Panel this year, they were able to continue their involvement, and examples include:

- Ongoing support to patients completing questionnaires as part of Real Time Patient Feedback;
- For the 8th year running helping with the Patient Environment Action Team (PEAT) inspection and making sure that the impartial view within the process is heard;
- One of the Panel members contributed to a national research study exploring important ways in which patients can help improve the safety of their care. The Patient Safety project was awarded "Runner up" for the category of "Communicating effectively with patients and families" at the PENNA awards 2011 (Patient Experience Network National Awards);
- Ongoing, active contributions to a number of Trust working groups and committees;
- Involvement with the preparations for the Standards of Care event 2011 and making a valuable contribution to the 'patient view' element of the programme;
- Helping with the development of the 'Your Stay in Hospital' guide and leading an evaluation of the folder with patients.

ix) PEAT inspections - making improvements to ensure our hospitals are safe and clean

The annual Patient Environment Action Team (PEAT) inspection is a self assessment and inspection exercise which measures standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). As in previous years, the PEAT inspection process has involved Trust Governor Representatives and members of our Community Panel, in addition to senior nursing, catering and facilities staff.

NHS Trusts are given scores from 1 (unacceptable) to 5 (excellent) for standards of privacy and dignity, environment and food within their buildings. The unannounced assessment took place in February 2012 and the results are compared with the 2010 and 2009 assessments below:

	Privacy & Dignity			Food			Environment		
	2009	2010	2011	2009	2010	2011	2009	2010	2011
Sunderland Royal Hospital	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Good* ●	Excellent ●
Sunderland Eye Infirmary	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Excellent ●	Good* ●	Excellent ●	Excellent ●

* This was identified incorrectly as 'Excellent' in last year's report

Governed by national standard definitions

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x) Privacy & dignity – our commitment to eliminating mixed sex accommodation

The Trust is committed to respectful and dignified care and meeting the national standards for same sex accommodation. Same sex accommodation means that patients will not share a sleeping area, bathroom or toilet with a member of the opposite sex even though they may be on a ward that cares for both men and women.

As part of the requirements, under the heading 'Eliminating Mixed Sex Accommodation', the organisation must have regard to recognising, reporting and eliminating breaches in single sex accommodation provision. The guidance states that all breaches of sleeping accommodation must be reported, for each patient affected, via the Unify2 system. Data has been made public from January 2011.

In this financial year to date we have had 3 breaches which all occurred during the month of June 2011:

- Patient on Chest Pain Assessment Unit (CPAU) was diagnosed as non cardiac but was not subsequently moved into an alternative ward within a 4 hour period from diagnosis (unjustified)
- 2 Patients (one male and one female - but the same incident) on CPAU diagnosed as non cardiac that could not be moved due to an outbreak of diarrhoea in a bay. Our policy is to move potentially infected patients into side rooms but there were none available at the time, so they had to remain in the bay to minimise the risk of spreading the infection (justified)

CPAU has now ensured increased awareness/vigilance and has implemented a checklist following a review of processes and lessons learnt through the root cause analysis.

Recent Estates work which has focused on eliminating mixed sex accommodation and improving patient dignity and privacy includes:

- Transfer of ICCU to the New Ward Block where all patients are treated in individual rooms,
- Opening of 120 beds in the New Ward Block, where patients have either individual bedrooms or larger, single sex bays with en-suite facilities,
- Ward E55 – the layout of the ward is not ideal and on occasion, depending on the ratio of male/female patients it was proving difficult for patients to access same sex toilet/bathing facilities. These patients have now been transferred to B28 and E55 has closed as a ward,
- Endoscopy – This department was designed with male and female recovery areas. However, due to the way the area was being used some privacy and dignity issues had developed. Separate male/female days are now organised where possible and minor estates alterations have taken place to alleviate the privacy and dignity issues,
- Interchangeable male/female signage has been provided to all single and multi-bed areas, toilet, bath and shower facilities.

All feasibility schemes continue to be vetted for compliance with same sex accommodation standards by the Capital Development Steering Group.

xi) Making improvements to our services

Improving quality using Lean tools and techniques

Lean is the Trust's chosen guiding philosophy and approach to improving the quality of patient services. Lean places an emphasis on what is of value to our patients. Using Lean tools and techniques we ensure that our energy and resources concentrate on quality from the patient's perspective. With a focus on delivering safe care, effective care and a first class patient experience we can identify the waste or non value adding activities in our systems and processes and do all that we can to remove them, freeing up more of our clinical and administrative time to do the things that matter to patients.

The Trust has been on its Lean journey since 2008. In 2011, there has been significant work to increase the organisation's capacity and capability to deliver Lean improvements. Training and coaching our senior clinicians and managers to enable them to lead improvements applying Lean has seen further benefits for our patients.

Patient Contact Centre

A contact centre has been established to provide easier access for patients who want to call us to cancel or rearrange their outpatient appointment. Previously there were 16 different numbers on 4 different sites and there was a call abandonment rate (patients put the phone down before speaking to a member of staff) of 29%. The contact centre has now been running for several months and we have seen call abandonment reduced to 9%. Further work is ongoing to improve the service early in the morning and at lunchtime.

Emergency Care Pathway

A significant project in 2011 has been the redesign of the emergency care pathway. Unnecessary steps have been removed from the A&E process to enable patients with minor injuries to be seen and treated quickly. A design for the emergency department, which will further improve patient flow, is underway.

The Productive Operating Theatre (TPOT)

Building on the Time to Care Programme, TPOT has been introduced to operating theatres. The aim of TPOT is to deliver the perfect operating list through visual management systems, process improvement and standardisation across the theatre complex. This project has supported theatre teams to reorganise and redesign the way they manage and do their work so there is now; i) an improved working environment,

ii) better management of equipment and stock, iii) turn around time has been reduced to enable operations to run more smoothly and iv) a reduction in the number of cancelled operations.

Enhanced Recovery Pathway

The Day of Surgery Admission (DOSA) and Perioperative Risk Evaluation and Preparation (PREP) systems have been improved and streamlined. Patients are better prepared for their surgery with the appropriate information being communicated at the right time. Furthermore the need for a pre-op overnight stay has been reduced. The DOSA environment has been redesigned and will be implemented in the coming year to further improve privacy and dignity for patients.

Radiology reporting

There have been considerable reductions in the time taken from a patient attending CHS for an x-ray to the results being reported back to their GP so that appropriate clinical management can progress. Before the improvement work GPs and patients would wait approximately 10 days for the results to be sent to the GP practice. Now the results are received by the practice within 2 days enabling the patient to receive appropriate treatment more quickly.

Bed Management and Discharge

A challenge for the organisation is to ensure that when patients are admitted to hospital we are able to access a bed in the most appropriate area to meet their clinical needs. Patients leaving hospital are now able to utilise a fully staffed discharge lounge and comfortably await their transport home. This frees up beds for new patients coming in to hospital earlier in the day enabling them to go to the right ward, first time.

In response to feedback from GPs a project to improve the timeliness and quality of discharge communication has been undertaken. Discharge letters which provide a clear and accurate picture of a patient's care whilst in hospital and the ongoing treatment plan are now provided electronically within 24 hours of the patient leaving hospital. This improves the quality of patient care provided to patients by community services following their hospital stay.

Urology: Prostate Cancer Pathway

In response to issues regarding the follow-up arrangements and partnership working between the trust and primary care colleagues, improvement work has been undertaken to agree a streamlined protocol for patients' ongoing management. In particular, having different protocols for patients living in Durham and Sunderland caused confusion for Trust clinicians. Agreeing a single, improved protocol for all patients has reduced the opportunities for misunderstanding and errors.

New Integrated Critical Care Unit

One of the most advanced integrated critical care units in the country opened to patients on Monday 11 April 2011 as part of the new £28m ward block at Sunderland Royal Hospital. The intensive care unit, including its outreach service to other parts of the Trust, is already a model for excellence in the NHS.

Staff, patients and relatives have had a major input in the design of the 18-bed department, and its development has focused particularly on infection control/hygiene, risk management and the privacy and dignity of users.

Reflecting the priority of the highest standards of infection control and a clean patient environment, specially designed dirty water disposal sinks have been developed by the Trust's Microbiology Department. Each room in the department also includes unique clinical

waste bins on the back walls, also specially designed by staff, which enable material to be emptied directly from the ICCU rooms to the external corridor, thus reducing the risk of infection to patients.

Special panoramic glass surrounding each room, which can be screened off for privacy at the flick of a switch, gives staff the best possible view of patients from the central ICCU staff corridor. Noise reduction for patients is also a crucial element in the design of each room, to ensure maximum patient comfort and privacy. One patient room has a dual function which allows it to be used as a staff training facility, as it is also equipped with microphones and cameras.

'This is one of the most carefully designed intensive care units in the country,' says unit manager Dave McNicholas. 'It gives patients and their families the reassurance that they are receiving the best possible treatment in the most modern of settings, with the latest equipment and the most highly trained staff'.

Outpatient Reminder Service Pilot

Over the past year more than 50,000 patients failed to attend their outpatient appointment at City Hospitals without giving any prior notice whatsoever. This is a significant waste of resources, which not only has a considerable negative impact upon the Trust financially but it can also affect how quickly the Trust can see and treat people. The Trust wanted to investigate ways of minimising the impact this has as much as possible, and ultimately provide a better service to patients by utilising doctors and nurses time more effectively.

During the year the Trust piloted a new outpatient reminder service within key areas that are most heavily affected by patients that do not attend (DNA) their appointment. These telephone 'reminder calls' were made around one week before the appointment was due to take place. The calls were made using both automated calls and calls made by call centre staff. The service was provided by a company called 360CRM, who are well established in this field and are widely used by other NHS organisations. The pilot commenced towards the end of June 2011 and was reviewed after four months. During this period the outpatient reminder service had resulted in a minimum of 30% improvement in the DNA rates across all specialties each month and an improvement was seen across each specialty individually.

Due to the success of the pilot, the Trust is now considering rolling this service out across all specialties; however it is important for this service to be integrated with the launch of the upgraded electronic patient administration system due towards the end of 2012.

Community Stroke Rehabilitation Team Win National Award

The Trust's Community Stroke Rehabilitation Service launched in September 2009, was commissioned by Sunderland Teaching PCT and involved stroke survivors and carers in both the development of the service standards and the procurement process. Since then, the multi-disciplinary Community Stroke Rehabilitation Team has worked tirelessly to establish the service and reduce the length of stay for stroke inpatients.

The team provides both early supported discharge and longer term community based multidisciplinary rehabilitation. The service operates seven days a week, visiting patients in hospital to introduce the team and identify rehabilitation, nursing and dietetic needs, and then visiting people at home within two days of leaving hospital. The team works closely with outpatient therapy services and The Stroke Association to ensure the person's needs continue to be met following discharge from the service.

The team has been awarded the Most Improved Stroke Service by the Stroke Association. Fiona Stewart, Clinical Coordinator and Speech & Language Therapist for City Hospitals Sunderland collected the award for Most Improved Stroke Service at the London awards ceremony. Judges commended the Community Stroke Rehabilitation Team for delivering outstanding post-hospital services, enabling stroke survivors to make a better recovery in the long-term.

Fiona says: "I am delighted that the team has been recognised by The Stroke Association for our efforts in supporting stroke survivors and their families in the community. Every member of the team believes passionately in the importance of Stroke Rehabilitation following the often life changing event of a stroke and we will continue to expand and improve the service in the future. We are currently developing surveys of stakeholders and families/carers in order to gain feedback on how we can further support the service."

Ken Bremner, Chief Executive of City Hospitals, says: "This is good news for patients and their families, and for the continued development of stroke services in Sunderland. A lot of people have worked extremely hard to ensure that this service has been commissioned and established - this award is for them and for the people of Sunderland."

Performance against key national priorities

During 2011/12 the Trust continued to maintain levels of performance above target in a number of key areas including national headline measures for MRSA bacteraemia, referral to treatment waiting times, cancer care and A&E waiting times.

The table below highlights the key national priorities, with the majority taken from the NHS Operating Framework 2011/12, many of which are also assessed as part of Monitor's compliance framework. Monitor, the regulator of Foundation Trusts produces a 'Governance' risk rating for each organisation and at the end of 2011/12, City Hospitals was rated Amber-Green because of our failure to achieve the *C. difficile* target.

Indicator	Last Year 2010/11	Target 2011/12	YTD 2011/12	YTD Variance	YTD
Quality (Safety, Effectiveness & Patient Safety)					
HCAI measure (MRSA)[1]	3	<6	1	-5	●
HCAI measure (CDI)[1]	49	<44	64	20	●
Patient Experience Survey	68.3	N/A	71.4	N/A	●
Referral to Treatment waits (95th percentile) admitted patients[2,3]	N/A	23 weeks	17.72	-5.28	●
Referral to Treatment waits (95th percentile) non-admitted patients[2,3]	N/A	18.3 weeks	13.74	-4.56	●
Referral to Treatment waits (95th percentile) incomplete pathways[2,3]	N/A	28 weeks	19.43	-8.57	●
MSSA Breaches[2]	N/A	N/A	3	N/A	●
A&E - Unplanned Re-attendance Rate[2]	N/A	5%	2.95%	-2.05%	●
A&E - Total Time in the A&E Department	95.64%	95%	95.49%	0.49%	●
A&E - Left Without Being Seen Rate[2]	N/A	5%	1.94%	-3.06%	●
A&E - Time to Initial Assessment[2]	N/A	15 mins	62	47	●
A&E - Time to Treatment[2]	N/A	60 mins	43	-17	●
All Cancer Two Week Wait	93.39%	93%	94.12%	1.12%	●
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	96.74%	93%	96.14%	3.14%	●
All Cancer 62 day urgent referral to treatment wait	86.49%	85%	89.08%	4.08%	●
62 day wait for first treatment following referral from an NHS Cancer Screening Service	95.24%	90%	95.83%	5.83%	●
31 day standard for cancer diagnosis to first definitive treatment	98.05%	96%	99.31%	3.31%	●
31 day standard for subsequent cancer treatments - surgery	98.10%	94%	99.28%	5.28%	●
31 day standard for subsequent cancer treatments - anti cancer drug regimens	100.00%	98%	100.00%	2.00%	●
Emergency Readmissions[4]	6.33%	<10/11	6.70%	0.37%	●
VTE risk assessment for inpatient admissions	59.46%[5]	90%	92.13%	2.13%	●
Quality (Safety, Effectiveness & Patient Safety)					
Quality stroke care - people who have a stroke who spend at least 90% of their time in hospital on a stroke unit	81.46%[6]	80%	85.05%	5.05%	●
Quality stroke care - people at high risk of stroke who experience a TIA are assessed and treated within 24 hours	N/A	60%	60.85%	0.85%	●
Maternity 12 weeks[7]	82.62%	90%	87.30%	-2.70%	●

[1] Cases apportioned to Acute Trust
[2] New indicator from the Operating Framework for 2011/12
[3] Latest monthly position
[4] CHKS sourced. 2011/12 position does not include March
[5] New indicator from the Operating Framework for 2010/11 (measured from June 2010)
[6] Quarter 4 2010/11
[7] Quarter 2 assessments divided by quarter 4 deliveries

Healthcare Associated Infection

The Trust achieved the national target for MRSA in 2011/12, however, the Trust failed to achieve the target for *C. difficile* infections. Due to the significant progress made by the Trust in 2010/11 to reduce the number of *C. difficile* infections, the target itself was more than halved from less than 98 cases in 2010/11 to less than 44 in 2011/12. This target has proved to be extremely challenging, despite a continued focus and commitment on reducing healthcare associated infections. We continue to look at ways to minimise the risk of patients developing these infections going forward into 2012/13. Further information on both these targets can be found within Part 1 of the Quality Report.

Referral to Treatment Waits

The NHS constitution sets out patients' rights to access services within the 18 week maximum waiting time from referral to treatment (RTT). In addition to ensuring that the percentage of patients seen within 18 weeks has not deteriorated during 2011/12, new targets were introduced that measure the 95th percentile waiting time for admitted and non admitted patients completing an RTT pathway, and similarly for incomplete pathways, i.e. those that were still waiting for treatment following referral. The Trust has consistently achieved a 95th percentile waiting time of around 18 weeks for admitted pathways in 2011/12, in comparison to a 23 week target. For non admitted pathways the Trust has consistently achieved the 18.3 week target, generally maintaining a 95th percentile waiting time of around 14 weeks and the Trust has been able to reduce the 95th percentile waiting time for incomplete pathways throughout the year from approximately 27 weeks to 19 weeks, compared to a 28 week target. The Trust is confident that RTT targets will continue to be achieved going forward.

Accident & Emergency (A&E)

During 2011/12 the Trust experienced significant operational pressures over the winter period with increased A&E attendances, and, on one occasion 447 patients attended the emergency department on a single day. There has also been an increase in the number of patients admitted to hospital from A&E and during the winter period a high proportion of patients with complex clinical conditions has required them to stay in hospital longer. Despite these pressures, the whole organisation has contributed towards delivery of the A&E target of 95% of patients spending less than 4 hours in the department. During 2012/13 we will continue to work with partner organisations such as GP practices, North East Ambulance Service, Community and Social Services to ensure Sunderland has a cohesive service for patients with urgent and emergency needs.

Cancer

The Trust achieved all cancer targets in 2011/12 and has continued to drive improvements to the cancer service resulting in a noticeable improvement between 2010/11 and 2011/12 to both the percentage of patients who received treatment for cancer within 31 days of a diagnosis and the percentage of patients who received treatment within 62 days from an urgent GP referral for suspected cancer.

The Trust has developed services such as the Acute Oncology Service, to better manage patients admitted with complications of their cancer and/or cancer treatment. This has resulted in a reduction in readmissions of cancer patients by around one third and a reduction of average length of stay by one day.

The Chemotherapy Unit was assessed against brand new peer review measures in 2011 and achieved compliance rates of between 85 and 100% across the standards. There is an implementation plan to introduce electronic prescribing which should allow us to achieve 100% in the future.

Pathways for certain types of cancer have been redesigned including the colorectal cancer patient pathway following the introduction of the Hamilton risk assessment which aims to detect Colorectal cancer at an earlier stage and developments to the Breast service with a one stop assessment service.

Venous-thromboembolism (VTE) Risk Assessments

The NHS Operating Framework for 2011/12 included a requirement that VTE risk assessments should be undertaken for at least 90% of patients admitted to hospital in order to reduce harm. The Trust has consistently achieved the target since the end of 2010/11 and has also been working towards additional quality indicators included in the Commissioning for Quality and Innovation (CQUIN) framework. These include offering VTE prophylaxis in accordance with NICE guidance to patients assessed to be at increased risk of VTE and offering patients and carers verbal and written information on VTE prevention as part of the admission process. CQUIN enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of national and local quality improvement goals.

Stroke

The Trust has achieved both national indicators in 2011/12 in relation to stroke care; the percentage of patients that spend more than 90% of their time in hospital on a stroke unit and people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours. The stroke team has continued to make improvements in the quality of stroke services, evidenced by a significant improvement in the proportion of patients who spend more than 90% of their time in hospital on a stroke unit increasing from 81.5% to 85.1% between 2010/11 and 2011/12. Delivery of high quality stroke services is also included in our CQUIN framework which takes into consideration the full package of care delivered to stroke patients in terms of acute care as well as post hospital discharge and longer term care, thus ensuring that appropriate screening, assessments and rehabilitation planning is completed where appropriate.

Maternity 12 weeks

The Trust continues to provide high standards of early access for women to maternity services, but due to difficulties in recording the first time women see a midwife or maternity healthcare professional, the performance has not been truly reflective of these high standards. During 2011/12 the Trust changed the process of capturing this data in order to address the issue, and this has resulted in a significant increase in performance from 82.3% in 2010/11 to 87.3% in 2011/12. Whilst this is slightly below the national target of 90%, the new process has not been in place long enough to realise the benefits of this process change. For this reason, achievement of the target is expected for 2012/13.

Actress Denise Welch opening the Macmillan Cancer Information Centre.

Statement from Lead Commissioner: Sunderland Teaching Primary Care Trust

NHS South of Tyne and Wear (serving Gateshead, South Tyneside and Sunderland PCTs) aims to commission safe and effective services that provide a positive experience for patients and carers. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. This responsibility is taken very seriously and considered to be an essential component of the commissioning function. During 2011/12 Sunderland Clinical Commissioning Group (CCG) has become actively involved in quality review processes.

Throughout 2011/12 monthly quality review meetings, with CCG representation, have taken place with City Hospitals Sunderland Foundation Trust. These are well established mechanisms to monitor the quality of the services provided and to encourage continuous quality improvement. The purpose of these meetings is to:

- monitor a broad range of quality indicators linked to patient safety, clinical effectiveness and patient experience
- review and discuss relevant trust reports e.g. Incident and Complaints reports
- review and discuss relevant external reports e.g. Care Quality Commission patient surveys
- monitor action plans arising from the above

A PCT Non-Executive Director has taken part in visits to City Hospitals Sunderland with a focus on infection control and patient experience.

There a number of areas where the trust has made quality improvements that have been important for patient care and to commissioners, for instance:

- care of stroke patients and patients with heart failure;
- use of pre-assessment to offer brief intervention for smoking;
- continued development of real-time feedback from patients;
- improved score in national inpatient survey;
- timeliness of X-ray reporting to GPs,
- timeliness and quality of discharge summaries.

The trust has experienced significant pressures within the Emergency Department but managed to achieve the national targets by the end of the year. The trust has implemented improvement initiatives within the emergency department. The trust also experienced significant challenges in relation to infection control targets for clostridium difficile and this is almost certain to continue to be a challenge in 2012/13. A health economy wide improvement plan has been initiated to improve clostridium difficile rates and Sunderland CCG will have oversight of progress against the plan. A new policy for reporting of serious incidents has been agreed with local trusts. Following ongoing discussions and concern about the low levels of reporting there is now evidence of improved reporting of serious incidents at City Hospitals Sunderland. Sunderland CCG particularly looks forward to continued improvement in x-ray reporting and discharge summaries.

It is positive that the priorities for 2012/13 have been identified with Governors and LINks and whilst they focus on strengthening the basics of healthcare there are also other improvement priorities for instance those with the 2012/13 CQUIN scheme particularly dementia care and reduction in harm from pressure ulcers.

Much of the information contained within this Quality Account is used as part of the quality monitoring process described above. As required by the NHS Quality Accounts regulations NHS South of Tyne and Wear has taken reasonable steps to check the accuracy of this information and can confirm that it is believed to be correct.

Date: 28 May 2012

Statement from Sunderland Local Involvement Network (LINk)

Sunderland LINk has pleasure in contributing to the Quality Report and we accept that certain data at the time of reading are incomplete.

In the spirit of constructive criticism, we were, at times, confused by the current presentation of data in graphical form and the accompanying narrative. Graphs were not always easy to read and the relevant narrative was not always a good match. On a simple presentational basis, it may help much to align a graph to its accompanying text, although it is accepted that this on occasions may present typographical problems.

In general, we think greater stress could be laid both on those indicators in which CHS is seen in a good light but at the same time also those where it is relatively poor. Reasons for the latter should always be given where possible and as is the case, followed through with an action plan to correct / improve performance with a given time frame. This could then be reported on, in the following year's report. Where poor performance exists still, further analysis is appropriate. This more staged developmental approach could be seen to be more in the spirit of continual improvement.

Certain findings proved worrying, such as the few cases where a patient was left unaccompanied when bad news had to be imparted, patient concerns on poor staff communication to them, (but this is not always easy to measure), pain management aspects, (although this is already fully acknowledged as an area for improvement) and finally adverse patient reports regarding the quality of food provided in fairness, there is already some evidence of improvement here.

With regard to 'Priority 2' we welcome the improvement on the presentation of food and its temperature, although it seems that the help to eat meals is still variable. Whilst it has made a great improvement since the low point in September, the results fluctuate to a degree which will still raise some concern for those who care for the vulnerable or elderly.

It is readily acknowledged that some of the contents are quite technical and have to be so, being based on the demands placed upon the Trust by higher bodies. At the same time, it may not therefore be easily followed by the lay person. There are number of examples, for instance;

Page 14 – In the Patient Safety table it is not clear what a 'never event' is and the explanation does not appear until page 31. Although professionals reading the document would understand what a 'never event' is, a lay person may have some difficulty.

To overcome this barrier to understanding, it could be beneficial to think in terms of producing a brief lay person's easy to read overview of the full Quality Report. For example, 'How Are We Doing?' which could highlight in simple narrative, both strengths of performance and those particular areas where CHS is striving to further improve the overall quality of experience for each and every patient.

On behalf of Sunderland LINk

Mike McNulty
Chair Sunderland LINk

Date: 24 May 2012

Statement from Overview and Scrutiny Committee (OSC)

Thank for you inviting our comments on the Quality Report for 2011/12.

The role of Overview and Scrutiny requires the Council, through its elected members, and working with our partner organisations, to reflect the voice of the service user to help improve services for everyone.

For the last two years we have worked with the staff at the hospital to review different aspects of service delivery. Firstly, we took a detailed look at the food provided in the hospital and we talked to many patients about what they thought. This was not just about whether patients liked the food but whether the food provided helped them to get better.

We know that a significant amount of work has been done to improve the mealtime experience and each month patients are asked about their experience in hospital, including the food. We are pleased to note that improvements are being reported by patients with many saying that their mealtime experience is much better.

We have just completed a review which included looking at the hospital discharge arrangements. Again, we talked to lots of patients and their families. It is reassuring to note that the majority were very happy with their experience in hospital, and with the arrangements made for their discharge. Of course, there are always some issues and concerns. Where issues formed a trend we reported this in our conclusions and these will be taken forward by the hospital to help make services better. We know that improvements are already underway, and we are aware that continuous improvement is sought in this and other services.

We look forward to working with the hospital in the year ahead to help to support progress.

Karen Brown

Karen Brown
Health Scrutiny Officer Date: 23 May 2012

Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended 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 reports (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 report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 28 May 2012
  - Feedback from governors dated 12 April 2012
  - Feedback from LINks dated 24 May 2012
  - Feedback from Overview and Scrutiny Committee dated 23 May 2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11 May 2012;
  - The national patient survey 24 April 2012;
  - The national staff survey 20 March 2012;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 April 2012; and
  - CQC quality and risk profiles dated April 2012.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report 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 Report (available at www.monitornhsft.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 Report.

By order of the Board

J N ANDERSON
Chairman Date: 29 May 2012

K W BREMNER
Chief Executive Date: 29 May 2012

Independent Auditors' Limited Assurance Report to the Board of Governors of City Hospitals Sunderland NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of City Hospitals Sunderland NHS Foundation Trust to perform an independent assurance engagement in respect of City Hospitals Sunderland NHS Foundation Trust's Quality Report (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA bacteraemia (page 5); and
- All cancer 62 day urgent referral to treatment wait (page 57).

We refer to these national priority indicators collectively as the "specified indicators".

Respective responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to below (the "Criteria"):

MRSA bacteraemia

- An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review);
- Reports of MRSA cases include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not, whether treated or not;
- The indicator excludes specimens taken on the day of admission or on the day following the day of admission;
- Specimens from admitted patients where an admission date has not been recorded, or where it cannot be determined if the patient was admitted, are also attributed to the trust; and
- Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

All cancer 62 day urgent referral to treatment wait

- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer;
- An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant (see http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103431.pdf);
- The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait);
- The clock start date is defined as the date that the referral is *received* by the Trust; and
- The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice (A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf). In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of the NHS Foundation Trusts ("Monitor"). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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 Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with Board minutes for the period April 2011 to April 2012;

- Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
- Feedback from the Commissioners dated 28/05/2012;
- Feedback from LINKS dated 24/04/12;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012;
- The 2011 national patient survey;
- The 2011 national staff survey;
- Care Quality Commission quality and risk profiles for the period April 2011 to April 2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated 29/05/2012.

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 Board of Governors of City Hospitals Sunderland NHS Foundation Trust as a body, to assist the Board of Governors in reporting City Hospitals Sunderland 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 2012, to enable the Board 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 Board of Governors as a body and City Hospitals Sunderland NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by City Hospitals Sunderland NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the documents; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP
Chartered Accountants
Newcastle Upon Tyne
30 May 2012

Arrangements for monitoring Improvements

Complaints Handling

City Hospitals Sunderland NHS Foundation Trust strives to provide the highest level of service to our patients. However, we recognise that there may be occasions when things go wrong and patients/relatives may not be entirely satisfied with the level of service they have received.

The Trust has an established complaints handling policy in line with the Department of Health's NHS and Social Care Complaints Regulations. This policy confirms that the Trust has a robust system in place to allow patients (or their nominated representative) the opportunity to have their concerns formally investigated and to receive a comprehensive written response from the Chief Executive.

The complaints handling policy is based on the principles of Good Complaints Handling published by the Parliamentary and Health Service Ombudsman. The key principles are as follows:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Whilst the current regulations stipulate a maximum timescale of six months to respond to a complaint, we aim to respond to complaints within twenty five working days. However, where a complaint is deemed to be complex, the timescale can be negotiated to allow additional time so that a thorough and comprehensive investigation may be undertaken.

The Trust welcomes both positive and negative feedback from our patients as a contribution towards improving the services we deliver. To ensure that the Trust is learning from experience, a quarterly report is submitted to the Clinical Governance Steering Group regarding complaints activity. This enables the group to identify and monitor trends and themes, and highlight any subsequent action to be taken within directorates to reduce the risk of recurrence.

From 1 April 2011 to 31 March 2012, the Trust received 534 formal complaints from patients or their representatives compared to 568 in 2010/11, a decrease of 6%.

Complaints Investigation

Formal complaints are allocated to an Investigating Officer within a Directorate, usually the Directorate Manager, who has responsibility for ensuring that a comprehensive investigation is undertaken. The Directorate Manager, in conjunction with his/her colleagues, is responsible for highlighting areas for improvement and ensuring appropriate action is taken.

The Chief Executive provides a formal written response to the complainant who is given the opportunity to contact the Investigating Officer to discuss any outstanding concerns. If the complainant remains dissatisfied following this conversation, they are offered the opportunity to attend a formal meeting with appropriate staff members to allow a more personal and open discussion in an attempt to provide further clarification and resolve any outstanding concerns.

Where complainants remain dissatisfied after conclusion of the meeting, and the Investigating Officer feels we have provided the complainant with as much information as possible then local resolution has been exhausted. In such cases, we would suggest the complainant contacts the Parliamentary and Health Service Ombudsman who may agree to undertake an independent review of their complaint.

Parliamentary and Health Service Ombudsman

During 2011/12, the Ombudsman requested information from the Trust in relation to 19 complaints, of these:

- 9 cases – satisfied with the Trust's investigation and no further action necessary.
- 9 cases – awaiting decision from Ombudsman.
- 1 case – Ombudsman suggested further local resolution.
- 0 cases – upheld.

Learning Lessons from Complaints

- Introduction of regular "comfort checks" on some wards to ensure properly documented patient checks
- Colour co-ordinated water jugs to easily identify patients who require assistance
- Introduction of red trays on all wards to indicate patients who need assistance with feeding
- Specific infection control guidelines developed for haematology patients
- Special arrangements in place with radiology to ensure priority investigation and return to ward for some vulnerable patients
- Recliner chairs bought so expectant fathers can be more comfortable awaiting the birth of a child.
- Review of clinical guidelines and procedures in a number of areas
- Redrafting of patient information and appointment letters.

Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) is available to provide advice and support, and to signpost patients, relatives and/or carers on a wide range of issues. PALS is responsible for dealing with enquiries which can be resolved by liaising with staff to reach a quick and effective resolution. During 2011/12, PALS received 562 contacts compared to 663 in 2010/11 which reflects a 15% decrease.

PALS collates and records feedback from the Listening to Patients Scheme, inviting patient feedback regarding their experience. Patients, relatives and visitors can complete a Listening to Patients card and post it in one of the various boxes situated around the Trust. The Trust received 11 Listening to Patients cards during 2011/12, compared to 21 in 2010/11.

"The Trust welcomes both positive and negative feedback from our patients as a contribution towards improving the services we deliver."

OFR: Stakeholder Relations

Significant Partnerships

The Trust is committed to partnership working and continues to play an active role not only within the health and social care economy in Sunderland but also within NHS North East.

We continue to have strong working relationships with our main Commissioner, Sunderland Teaching Primary Care Trust particularly at a time when they are striving to manage the transition to the establishment of Clinical Commissioning Groups. A key area for the Trust going forward will be the development of our relationship with the new GP commissioners.

Within the South of Tyne and Wear (SOTW) area there has always been a strong track record of partnership working, clinical networks and a general willingness to engage with each other to help overcome the many challenges that arise when working within the NHS. As a consequence the collaborative and 'Bigger Picture' thinking was set up to work towards a shared vision of how services may look in the future – utilising the strengths of each organisation to balance healthcare provision across SOTW using resources most effectively to create sustainable quality services for the future.

A key focus this year has been the development of a paediatric consultation document which proposes changes to paediatric inpatient care and short-stay assessment units.

Work is also currently being undertaken to look at the development of a pathology network with one centre of excellence laboratory working on behalf of the three hospitals in Sunderland, Gateshead and South Tyneside, with a 'hot' laboratory on each site. A detailed proposal is currently being developed.

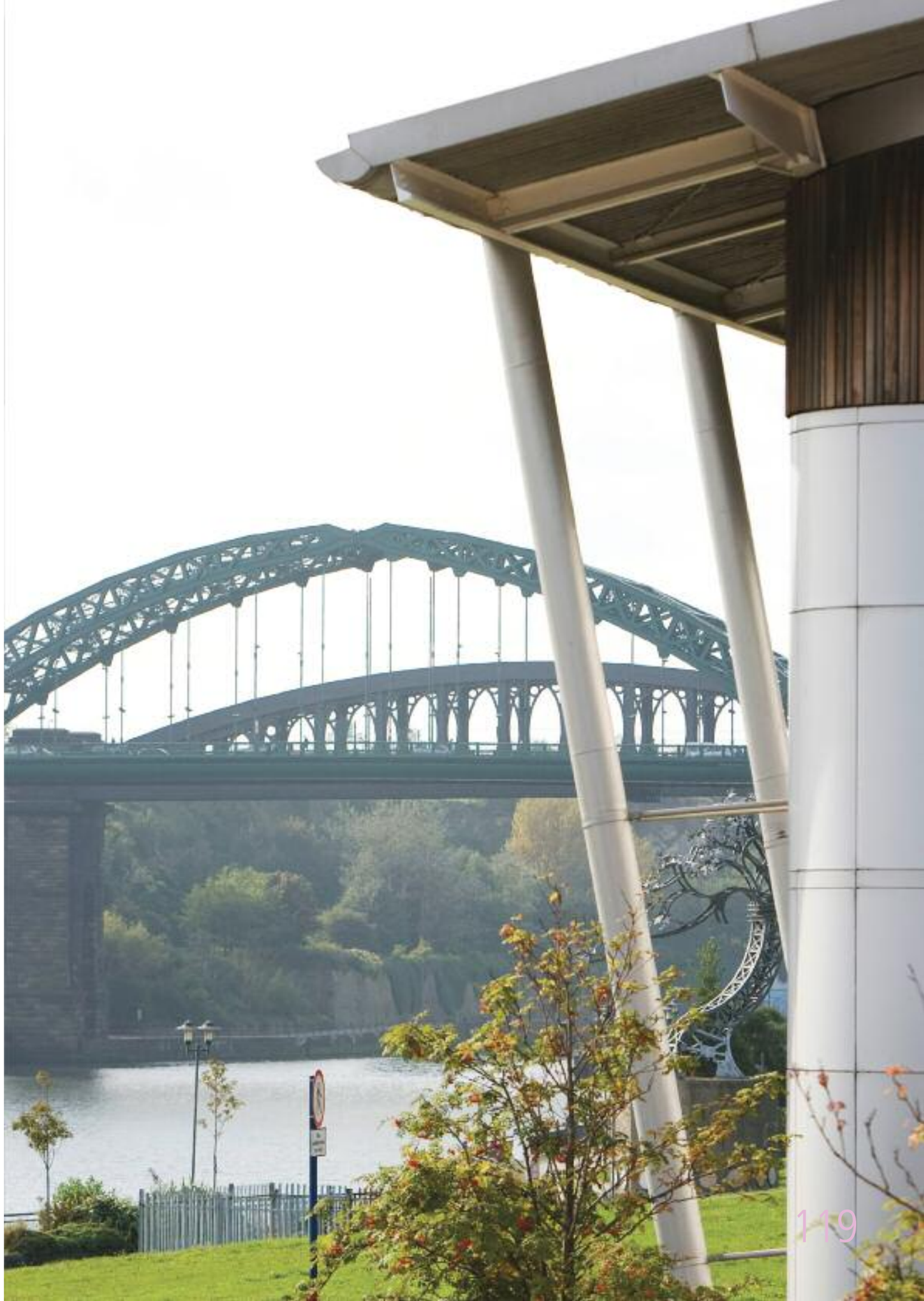
As more and more areas of collaboration are being proposed a number of engagement events will be held to seek views and thoughts going forward.

The Trust continues to maintain and develop a strong working relationship with the City of Sunderland and is an active member of a number of city wide groups:

- Partnership Executive Board(chaired by Ken Bremner, Chief Executive of CHS)
- Partnership Innovation and Improvement Group
- Economic Leadership Board;
- Safeguarding Adults Partnership Board and associated sub committees;
- Children's Trust Board;
- Local Safeguarding Children's Board and associated sub committees;
- Corporate Consultation Group; and
- Compact Delivery Group

The City of Sunderland established its Health and Wellbeing Board but the Trust was not given a seat on the Board. We do however, have the opportunity to influence policy through our attendance at the Economic Leadership and Adult Partnership Board.

The Trust is also an active member of the working group developing the City's Health and Wellbeing Strategy.



OFR: Finance

The Trust experienced a number of significant challenges during the year, starting right from the start of the financial year. Improved ward capacity became available with the opening of the Jubilee Wing development in March 2011 thus allowing the closure of older facilities. Thanks to the work undertaken during 2010/11 focusing on reducing inappropriately long length of stay for patients, this meant that the Trust was able to close two wards at the start of the year. However, during the year, the Trust faced unprecedented activity demand pressures, particularly within elective activity at 12.2% higher than plan, which continued all year. Emergency activity pressures were relatively static until the last few months of the year when combined with the continuing elective pressures there were significant operational challenges. A&E attendances continued to be a cause for concern in terms of the increasing complexity and the volume of attendances, again higher than originally planned.

Contracts for the year reflected the updated tariff arrangements. For 2011/12 the Operating Framework reinforced a number of themes and introduced new principles. The 'marginal' rate received for any emergency patients seen over and above the number of patients seen at the end of 2008/09 continued to be in place. Given the relatively stable position expected in 2011/12, this did not have a material impact on the year. Of more concern was the introduction of a national principle relating to readmissions. The principle was that NHS Trusts would be de-funded for any readmissions into the Trust within 30 days, subject to a number of exclusions. The concept was to encourage appropriate support mechanisms for patients so that where avoidable they did not return to hospital. As a new funding principle the Trust agreed with its commissioners a mechanism to manage the risk and work with the commissioners to better understand what processes needed to be in place to support patients better. This principle continues into 2012/13.

Within this environment, the Trust and commissioners agreed activity levels predominantly based on 2010/11 actual activity plus anticipated additional growth requirements to achieve the necessary targets. The national tariff assumed a gross inflationary funding of 2.5% offset by an assumed level of 4% cash releasing efficiency. As a result therefore, tariff prices reduced in net terms by 1.5%. The impact of this efficiency requirement plus other Trust pressures such as the loan repayments for the Jubilee wing facility resulted in the need for an external cost improvement requirement of £12.1m to ensure all pressures including inflationary pressures were fully funded.

The Trust had submitted and agreed a financial plan with Monitor (the regulatory body for Foundation Trusts) which showed a planned surplus of £2m for the year. The plan assumed no drawdown from the working capital facility with planned cash balances of £16.1m as at the 31st March 2012. The plan was based on no over performance in clinical activity and upon successful delivery of cost reduction measures of £12.1m.

The Trust's financial statements are presented later in this report.

Looking Forward

The National financial agenda remains challenging, with continued pressure on public sector funding, including the NHS. The indications are that much of the efficiencies required to deliver this will be required from hospitals, with increasing pressure on tariff funded services being applied. The expectation for the Trust therefore is that service planning and major pathway reform will be required across the hospital, community and social service sectors in order to deliver the efficiencies in services required.

The Trust has continued to work with colleagues across the South of Tyne community to assess and prepare for the impact of reduced funding through tariff prices and the expectations around reducing patient numbers into hospital highlighted in the Operating Framework for 2012/13. Plans have been developed to significantly reduce the cost base of the organisation in 2012/13, with further savings to be made in subsequent years.

For 2012/13, the full impact of the NHS standard contract will apply. The 'Commissioning for Quality and Innovation' (CQUIN) payment scheme, has increased by 1% to 2.5% of overall clinical income and gives an opportunity for the Trust to 'earn' additional funding by delivering a range of improved quality measures.

As a principle the Trust has therefore set budgets for 2012/13 based upon the underlying outturn position from 2011/12. The national tariff assumes a gross inflationary funding of 2.2% offset by an assumed level of 4.0% cash releasing efficiency. Therefore the overall price paid by commissioners for patients seen and treated in hospital settings will reduce by a net 1.8% compared with 2011/12. In addition, in 2012/13 the contracting rules continue to assume non payment for hospital readmissions within 30 days of discharge from the hospital. The Trust will be continuing to work closely with commissioners to assess the impact of this and look at ways of reducing any potential avoidable readmissions back into hospital and improve patient experience.

As a result, the Trust has set a Cost Improvement Target of 6% of the cost base. This will be delivered with individual plans each having a managerial and Clinical Director lead, ultimately feeding into the Finance Committee monitoring process to ensure delivery.

Overall the budget has been set at a surplus of £2m with a continued positive cash balance at the end of 2012/13.

Cost Improvement Programme Plans

Divisional Plans for cost improvements were agreed at the start of the 2011/12 financial year. Included in the Annual Plan was a target of £12.1m, although internal plans were set higher. The Trust delivered the external target, with good progress made towards achieving the internal target. The overall achievement was £17.9m.

The Divisional Directors were responsible for the delivery of the targets and progress against plan was reported regularly to the Finance Sub-Committee which is led by Non-Executive Directors.

Surplus

The Organisation achieved a surplus of £3.78m for the year.

The cash position was ahead of plan at £19.95m at the year end against a target of £16.15m with no drawdown from the working capital facility.

Capital Funding and Prudential Borrowing Limit

The Trust had an allocated Prudential Borrowing Limit of £62.6m. At the start of the year, the Trust had an outstanding balance on a number of Foundation Trust Financing Facility (FTFF) loans of £33.28m. By the end of the financial year the balance outstanding was £32.26m.

Capital investment in 2011/12 was predominately funded from internally generated funds only. Total capital investments included the upgraded patient information system, the final phase of demolition of old buildings to create car parking, medical equipment replacement and IT investment. The Trust has also continued to invest in backlog maintenance for its buildings.

Cash Flow Management

The Trust has not utilised any of its agreed working capital facility during 2011/12. CHS has adhered to the Public Sector Policy regarding payment of creditors during the year.

The cash balances at the year end were £19.95m, ahead of the plan of £16.15m partially due to some slippage on the capital programme in year, but also the payment of over performance invoices reflecting a marginal net gain against costs incurred.

Financial Risks 2012/13

The key financial risks facing the organisation in 2012/13 are likely to be significant. The national financial environment continues to be challenging. Within this context the impact of the introduction of the NHS Bill will result in changes to the commissioning environment. Clinical Commissioning Groups (CCGs) will take a lead role during 2012/13 and are likely to approach the commissioning role in a different way to their predecessor Primary Care Trusts (PCTs). This could result in increasing financial volatility for the Trust as new relationships are developed.

A continuing risk related to the successful delivery of the CIP and other cost reduction measures associated with improved efficiency and productivity given the recurrent need to meet the efficiency target inherent in the national tariffs and the targeted resource releasing initiatives from the PCT plans. With the roll-out of the SLR system, greater information will now be available to support Directorates in better understanding their costs and matching this through to income to understand the risks.

A major element of the CIP plans is based on the implementation of 'Corporate Projects' looking to reduce the cost base by improving efficiency or reviewing the patient pathway, but at the same time improving quality and the patient experience. In some cases this will result in a reduction in the facilities provided as they will no longer be required. Previous experience demonstrates that where activity pressures are greater than expected, facilities are required to remain open to support the required increase in capacity. There are therefore risks that there could be a delay in reducing costs associated with any reduction.

The other major future risk concerns the Trust receiving a number of equal pay claims and these have been included in the final accounts for 2011/12 as a contingent liability. At this stage, it is difficult to quantify the potential financial implications of these claims should they prove successful.

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent to which, performance occurs e.g. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Credit risk is the possibility that other parties might fail to pay amounts due to the Foundation Trust. Credit risk arises from deposits with banks as well as credit exposures to the Foundation Trust's commissioners and other debtors. Surplus operating cash is only invested with the National Loans Fund. The Foundation Trust's cash assets are held with Lloyds and the Government Banking Service (GBS) only. The Foundation Trust's net operating costs are incurred largely under annual contracts with local primary care trusts, which are financed from resources voted annually by Parliament.

The NHS Foundation Trust receives cash each month based on the agreed level of contract activity and there are quarterly payments/deductions made to adjust for the actual income due under the tariff system. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. To alleviate this issue the NHS Foundation Trust has maintained an £18,000,000 working capital facility with its current Bankers, which was not utilised in 2011/12.

Related Party Transactions

The Trust has a system in place to identify all new related party transactions. As NHS Foundation Trusts and NHS Trusts have common control through the Secretary of State, there is an assumption that Government Departments and agencies of Government Departments are related parties. The material transactions have mainly been undertaken with other NHS bodies and other Government Departments, predominantly being the University of Newcastle. NHS bodies are summarised as:

Department of Health

North East Strategic Health Authority

A number of Primary Care Trusts, including Sunderland, South Tyneside, Gateshead and County Durham

Northumberland Tyne & Wear Mental Health Trust

County Durham and Darlington NHS Foundation Trust

Newcastle upon Tyne NHS Foundation Trust

North East Ambulance Service

South Tyneside NHS Foundation Trust

National Blood Authority

Prescription Pricing Authority

NHS Litigation Authority

Financial Performance

For the financial year 2011/12 key headline financial indicators are as follows:

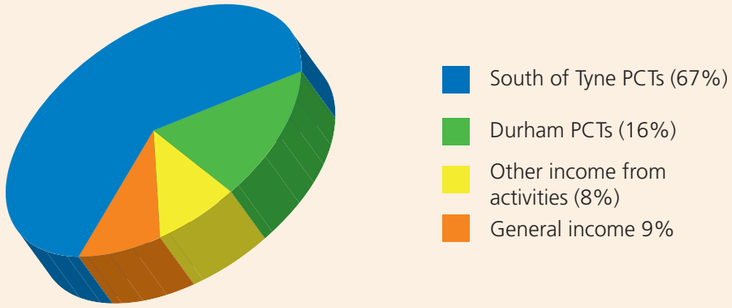
- The year ended with a surplus of £3.78m;
- The year ended with cash balances of £19.15m with no draw down on the working capital facility;
- Capital Investment of £6.1m
- Private Patient Income of £438k or 0.14% of turnover (well within our formal cap).

Financial Headlines

2011/12	Million
Operating Income	306.02
Operating Expenditure	295.61
Dividends paid	5.36
Surplus	3.78
Capital Expenditure	6.10
Total Fixed Assets	**205.37**

All income totalled £306m, a breakdown of the key sources is shown below:

Source of Income 2011/12

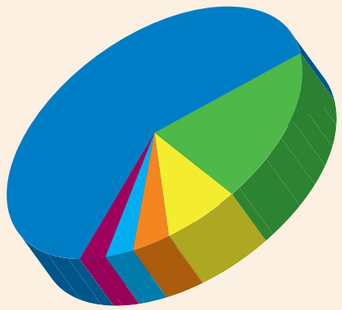


Expenditure

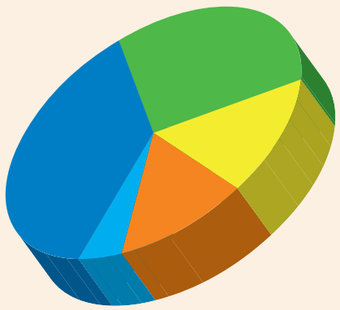
Expenditure amounted to £295.6m. The majority of expenditure (64%) related to staff costs at £188.3m.

Full Details of Directors' Remuneration are included in the Annual Report on page 144.

Expenditure 2011/12



Staff Analysis 2011/12



Planned Investment Activity

Capital expenditure in 2011/12 totalled £6.1m with significant investment in premises, medical equipment and information technology.

	Million
Premises (including Backlog maintenance, Demolition and Car Parks)	2.48
IT Systems (including Meditech V6 Upgrade)	2.39
Medical Equipment	0.67
Paging System Upgrade	0.25
'Silver' Command Centre	0.13
Radiology Equipment	0.12
Vehicles	0.05
Miscellaneous	0.01

The value of the Trust's fixed assets, both Tangible and Intangible, at the end of 2011/12 was £205.37m.

It is anticipated that, in 2012/13, capital investment will be funded via internally generated resources plus a further FTFF approved loan for the development of a new Multi Storey Car Park (MSCP).

The Trust has in place a process to review the planned replacement of Medical Equipment and this includes a review of lease versus purchase for more substantial schemes.

Charitable Funds

The Board of Directors acts for the Corporate Trustee for all "Funds Held on Trust" which are registered with the Charities Commission as a single charity. The Trust continues to receive donations from a wide variety of benefactors for which it is extremely grateful, and continues to utilise these funds for the benefit of both patients and staff in accordance with the terms of the donation. During 2011/12 the 'Charitable Funds Committee' represented the Corporate Trustee in the day to day management of the funds.

As at 31st March 2012, the pre-audit value of the funds held on trust amounted to £2.95m, a decrease of £0.10m over the final 2010/11 position (£3.05m).

The value of income received amounted to £0.60m (£1.35m final position as at 2010/11) and the value or resources expended amounted to £0.70m (£0.90m final position as at 2010/11). Within this, £28k was spent on Research (£18k final position as at 2010/11). Capital purchases of equipment total £199k (£363k final position as at 2010/11), for departments including Neonatology, Obstetrics and Gynaecology, Renal, Rheumatology, Neurology, ICCU, ENT and Ophthalmology.

The Investment Portfolio at 31st March 2012 stood at £1.43m (£1.44m final position as at 31st March 2011), a decrease of £0.01m. During the year the FTSE100 fell by 2% from 5,909 to 5,706.

Going Concern

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts and annual report.

JULIA PATTISON
Director of Finance

NHS FOUNDATION TRUST CODE OF GOVERNANCE

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and the Board of Governors of the Trust are committed to the principles of good corporate governance as detailed in the NHS Foundation Trust Code of Governance.

The Board of Directors has considered the Code of Governance and is compliant with the Code as evidenced in the following section of the Annual Report.

Board of Directors 2011/12

John Anderson QA CBE, Chairman

Initial Appointment: October 2008
Reappointed: September 2011 (3 yrs)

Mr Anderson sold his main business (Mill Garage Group) in 1993 and has since devoted his time to Public/Private Partnerships. He is Regional Chairman of Coutts & Co (Private Banking) RBS Group, Sun FM and Durham FM Radio. He is Executive Chairman of Milltech Training Ltd, a company that assists young people into work through apprenticeships. He is Chairman of the North East Business and Innovation Centre.

Committee Member: Board of Directors; Finance Committee.

Bryan Charlton, Non Executive Director

Initial Appointment: February 1998
Reappointed: June 2005 (3 yrs)
Reappointed: June 2008 (9 mths)
Reappointed: March 2009 (18 mths)
Reappointed: September 2010 (12 mths)
Retired: September 2011

Councillor Charlton has been an active Trade Unionist and Shop Steward since 1969. He has been a local councillor since 1987 and has held the post of Deputy Leader of Sunderland City Council. He is also a School Governor of Hylton Redhouse Comprehensive School. He retired from the Board at the AGM in September 2011.

Committee Member: Board of Directors; Remuneration Committee, Tendering Committee.

David Clifford OBE DL, Vice Chairman, Non Executive Director and Senior Independent Director

Initial Appointment: **November 2002**
Reappointed: **November 2006 (3 yrs)**
Reappointed: **November 2009 (12 mths)**
Reappointed: **September 2010 (12 mths)**
Reappointed: **September 2011 (12 mths)**

Mr Clifford has 40 years experience in the region's ports and transport industries. He retired as Managing Director at the Port of Tyne Authority in 2002. He has previously been Chairman of South Tyneside Enterprise Partnership and of East Durham Groundwork Trust and is a member of other regional committees. He is a member of the Foundation Trust Financing Facility, a national committee. He is a Deputy Lieutenant of County Durham.

Committee Member: Board of Directors; Audit Committee; Remuneration Committee; Finance Committee; Operations Committee.

Mike Davison, Non Executive Director

Initial Appointment: **April 2007**
Reappointed: **April 2009 (18 mths)**
Reappointed: **September 2010 (2yrs)**

Mr Davison is a qualified Chartered Management Accountant and until his retirement at the end of March 2008 was Finance Director at the Port of Tyne Authority from 1995. He is an independent member of the Newcastle University Audit Committee and an independent adviser to the Church Society Finance Committee based in London. He is also a Church Elder.

Committee Member: Board of Directors; Tendering Committee; Governance Committee; Policy Committee; Security Champion.

Miriam Harte, Non Executive Director

Initial Appointment: **September 2007**
Reappointed: **September 2009 (2 yrs)**
Reappointed: **September 2011 (2 yrs)**

Ms Harte is a qualified Chartered Accountant and also holds a law degree. She worked for 12 years for Proctor and Gamble and then moved to the Museum Sector. She was the Director of Bede's World (1998-2001) and then Beamish (2001-2007) and now works independently on museum/heritage projects, including most recently the Great North Museum. She is a Director of Audiences North East and is a Deputy Lieutenant of County Durham.

Committee Member: Board of Directors; Audit Committee; Tendering Committee; Patient and Public Involvement Committee; Charitable Funds Committee. Equality and Diversity Champion.

Stewart Hindmarsh, Non Executive Director

Initial Appointment: **January 2012 (2 yrs and 9 mths)**

Mr Hindmarsh is Chairman and Managing Director of an Advertising and Marketing Company in Sunderland. He is also Chairman and Managing Director of Cedars Nursery Ltd, and Vice Chairman of JG Windows, the music store.

Committee Member: Board of Directors; Operations Committee.

Roy Neville, Non Executive Director

Initial Appointment: **February 2005**
Reappointed: **January 2009 (20 mths)**
Reappointed: **September 2011 (12 mths)**

Mr Neville is a qualified Chartered Accountant and prior to his retirement was Managing Director of a Seaham-based family firm. He has previously held the posts of Chair of the Governors of Seaham Comprehensive School, Governor of Ropery Walk Junior and Infants School, Chair of Parkside Community Centre and Chair of the Seaham Initiative, a regeneration project.

Committee Member: Board of Directors; Audit Committee; Finance Committee; Charitable Funds Committee; Control of Infection Champion and Counter Fraud Champion.

David Barnes, 'Shadow' Non Executive Director

Initial Appointment: **January 2012 (9 mths)**

Mr Barnes is a qualified Chartered Accountant and acts as a consultant to his previous firm TTR Barnes based in Sunderland. He is a Trustee and Audit Chair of the United Church Schools . Prior to his appointment as a 'Shadow' Non Executive Director he was a Non Executive Director of Sunderland Teaching Primary Care Trust and also held its appointed Governor position to the Trust's Board of Governors.

As a "shadow" Non Executive Director Mr Barnes currently has no voting rights at the Board.

Mr Barnes will formally replace Mr Neville upon his retirement at the end of September 2012

Committee Member: Board of Directors; Audit Committee; Finance Committee.

Ken Bremner, Chief Executive

From February 2004

Mr Bremner is a qualified accountant and joined the Trust in 1988 becoming the Finance Director in 1994. He became Deputy Chief Executive in 1998 and Chief Executive in 2004. Mr Bremner is a member of the SAFC Foundation of Light Development Board and chairs the Sunderland Partnership Executive.

Committee Member: Board of Directors; Remuneration Committee (for Executive Directors only); Finance Committee.

Les Boobis, Medical Director

From November 2004

Mr Boobis joined City Hospitals in 1988 as a Consultant General and Vascular Surgeon and continues to combine this role with that of Medical Director. He has previously held the posts of Deputy Medical Director and Clinical Director for General Surgery and Urology within the Trust. Mr Boobis is also a Senior Lecturer in Surgery at the University of Newcastle Upon Tyne and a visiting Professor of Sports Medicine at the University of Loughborough (until August 2011).

Committee Member: Board of Directors; Governance Committee.

Julia Pattison, Director of Finance

From July 2008

Mrs Pattison is a qualified accountant and has worked in the NHS since 1989. She joined the Trust in May 2006 as Head of Finance and Contracting previously working as Head of Finance and Service Level Agreements at North of Tyne Commissioning Consortium. Mrs Pattison became Director of Finance in July 2008.

Committee Member: Board of Directors; Governance Committee; Tendering Committee; Finance Committee; Charitable Funds Committee.

Joy Akehurst, Director of Nursing and Quality

From July 2011

Mrs Akehurst is a registered nurse and has worked in the NHS since 1982 and joined the Trust in July 2011 from the post of Associate Director – Quality and Patient Safety, NHS South of Tyne and Wear.

Committee Member: Board of Directors; Governance Committee; Operations Committee; Patient and Public Involvement Committee.

Mark Smith, Chief Operating Officer

From December 2008

Dr Smith joined the Trust on secondment in December 2008 and was appointed to the substantive post in December 2009. He previously worked as a GP in North Tyneside before joining the North East Strategic Health Authority in 2005 as Deputy Medical Director and Head of Commissioning.

Committee Member: Board of Directors; Governance Committee; Operations Committee.

Carol Harries, Trust Secretary, Director of Corporate Affairs

From 1999

Mrs Harries has worked in the NHS since 1971 and joined the Trust in 1996 from the post of Unit General Manager at South Durham Healthcare Trust. Mrs Harries became Trust Secretary in 1999. She is a Trustee of Age Concern Sunderland.

Register of Interests

A Register of Interests for the Board of Directors is maintained by the Trust Secretary. The format of this register was agreed by the Board of Governors in August 2004. The register is available for inspection by members of the public via application to the Trust Secretary.

Appointment of the Chairman and Non Executive Directors

It is for the Board of Governors at a general meeting to appoint or remove the Chairman and other Non Executive Directors. Removal of a Non Executive Director requires the approval of three-quarters of the members of the Board of Governors.

The Chairman, John Anderson, was appointed to the Trust on 1 October 2008 for an initial three year term. The Board of Governors extended Mr Anderson's appointment in September 2011 for a further three years.

Mr David Clifford, Vice Chairman was initially appointed to the NHS Foundation Trust at its creation in July 2004 for the unexpired period of his term of office. Mr Clifford was re-appointed in November 2006 for a further three years and again in November 2009 for a further year and an additional year from September 2010 until September 2011. The Board of Governors agreed to extend Mr Clifford's appointment for an additional year until September 2012 when he will retire.

Mr Clifford became Vice Chairman in November 2006 and Senior Independent Director in March 2007.

Mr Mike Davison, Non Executive Director was appointed in April 2007 for an initial period of two years. Mr Davison was re-appointed in January 2009 for a further eighteen months until September 2010 and again for a further two years until September 2012.

Ms Miriam Harte, Non Executive Director was appointed in September 2007 for a period of two years. Ms Harte was re-appointed in September 2009 for a further two years until September 2011 and again for a further two years until September 2013.

Mr Stewart Hindmarsh, Non Executive Director was appointed in January 2012 for an initial period of two years and nine months.

Mr Roy Neville, Non Executive Director was appointed in February 2005 for a period of four years. Mr Neville was re-appointed in January 2009 until September 2011 and then for a further twelve months until September 2012 when he will retire.

All appointments are made for a period of office in accordance with the terms and conditions of office decided by the Board of Governors. At its meeting in January 2009 Governors agreed that renewal dates would be adjusted for approval at future AGMs held in September to allow orderly succession.

Following a successful recruitment campaign the Nominations Committee made a recommendation to the Board of Governors to offer Mr David Barnes a Non Executive Director position to replace Mr Neville when he retires at the end of September 2012. Given the complexities of NHS finance and those of a large acute Foundation Trust the Nomination Committee felt it beneficial for Mr Barnes to 'shadow' appointment from 18 January 2012 to follow through the year end, budget setting, cost improvement programmes and annual accounts process. This would ensure that from 1 October 2012 Mr Barnes would be fully cognisant of the financial regimes within the Trust to take over the Finance Committee functions previously held by Mr Neville.

Mr Barnes would be a 'shadow' appointment and therefore have no formal voting rights until his substantive appointment from 1 October 2012.

The Board is now at full strength and has a balance of skills and experience for the business of the Trust. The Board, excluding the Chairman, now has a 50/50 split of Executive and Non Executive Directors.

The Non Executive Directors bring an independent judgement on issues of strategy, performance, risk, quality and people through their contribution at Board and workshop meetings.

The Board has concluded that each of the Non Executive Directors is independent in accordance with the criteria set out in the NHS Foundation Trust Code of Governance. At the time of his appointment, the Chairman, Mr John Anderson, was considered independent in accordance with the Code of Governance.

The Chairman and the Non Executive Directors meet regularly without the Executive Directors being present.

The roles of the Chairman and the Chief Executive are separate.

Board Evaluation

Individual evaluation of both the Executive and Non Executive Directors was undertaken in 2011/12. As part of this process the Chairman undertook one-to-one sessions with the Non Executive Directors and Chief Executive.

The Chief Executive carried out formal appraisals of each of the Executive Directors. The Vice Chairman met all Non Executive Directors and the Lead Governor individually to review the Chairman's performance.

Following this evaluation, the Directors have concluded that the Board and its Committees operate effectively and also consider that each Director is contributing to the overall effectiveness and success of the Trust and demonstrates commitment to the role.

Board Purpose

The Board of Directors determines the strategic direction of the Trust and reviews and monitors operating, financial and risk performance.

A formal schedule of matters reserved to the Board includes:

- approval of the Trust's Annual Plan;
- adoption of policies and standards on financial and non-financial risks;
- approval of significant transactions above defined limits and;
- the scope of delegations to Board Committees and the senior management of the Trust

The Executive Committee of the Trust is responsible to the Board for:

- developing strategy;
- overall performance of the Trust, and managing the day to day business of the Trust

The matters reserved to the Board of Governors are:

- to appoint, or remove the Chairman and the other Non Executive Directors of the Trust;
- to decide the remuneration and allowances of the Chairman and Non Executive Directors;
- to appoint or remove the Trust's auditor;
- to be presented with the annual accounts and annual report;
- to approve an appointment by the Chairman and Non Executive Directors of the Chief Executive, and
- to give the views of the Board of Governors to Directors for the purposes of preparing by the Directors, the Trust's Annual Plan.

> "The Board of Directors should ensure that the NHS Foundation Trust exercises its functions effectively, efficiently and economically."

Meetings of the Board of Directors

Board of Directors		Number of Meetings	Actual Attendance
John Anderson	- Chairman	11	11
Joy Akehurst[1]	- Director of Nursing	7	5
Ken Bremner	- Chief Executive	11	10
Les Boobis	- Medical Director	11	9
David Clifford	- Non Executive Director	11	11
Bryan Charlton[2]	- Non Executive Director	6	1
Mike Davison	- Non Executive Director	11	10
Miriam Harte	- Non Executive Director	11	11
Stewart Hindmarsh[3]	- Non Executive Director	3	2
Roy Neville	- Non Executive Director	11	11
Julia Pattison	- Director of Finance	11	11
Mark Smith	- Chief Operating Officer	11	11

Audit Committee	Number of Meetings	Actual Attendance
Roy Neville, Chair	4	4
David Clifford	4	4
Miriam Harte	4	3

Charitable Funds Committee	Number of Meetings	Actual Attendance
Roy Neville, Chair	3	3
Miriam Harte	3	3
Julia Pattison	3	2

Finance Committee	Number of Meetings	Actual Attendance
Roy Neville, Chair	10	10
John Anderson	10	8
Ken Bremner	10	10
David Clifford	10	9
Julia Pattison	10	10

Governance Committee	Number of Meetings	Actual Attendance
Mike Davison, Chair	8	8
Joy Akehurst[1]	6	4
Les Boobis	8	5
Julia Pattison	8	7
Mark Smith	8	3

Nominations Committee	Number of Meetings	Actual Attendance
David Clifford, Chair	3	3
John Anderson	3	3
Ken Bremner	3	3
Duncan Stephen, Governor	3	3
Ian Tunnicliffe, Governor	3	3

Operations Committee	Number of Meetings	Actual Attendance
David Clifford, Chair	8	8
Joy Akehurst[1]	5	1
Mark Smith	8	8

Patient & Public Involvement Committee[4]	Number of Meetings	Actual Attendance
Miriam Harte, Chair	3	3
Joy Akehurst[1]	3	2

Remuneration Committee	Number of Meetings	Actual Attendance
David Clifford, Chair	2	2
Bryan Charlton	2	2
Miriam Harte	2	2
Ken Bremner (for Executive Directors only)	2	2

Remuneration Committee	Number of Meetings	Actual Attendance
Bryan Charlton, Chair[2]	3	0
Mike Davison	7	5
Miriam Harte, Chair[5]	7	6
Julia Pattison	7	7

[1] Joy Akehurst only commenced 4 July 2011.

[2] Bryan Charlton was ill during 2011 and retired at 30 September 2011.

[3] Stewart Hindmarsh was only appointed from 1 January 2012.

[4] Patient and Public Involvement Committee was only established as a formal sub committee of the Board of Directors in January 2012.

[5] Miriam Harte became Chair from 1 October 2011 following the retirement of Bryan Charlton.

Steven Greenhalgh one of the Trust's joiners who provide a valuable service to wards and departments.

AUDIT

Audit Committee

The Audit Committee has reviewed and commented upon the internal and external audit plans and the Local Counter Fraud plan. With regard to internal audit and Local Counter Fraud Service (LCFS) reports it has reviewed their reports and updates on the basis of the report recommendations, and on a sample basis, the complete report.

The Committee has reviewed in detail the Annual Accounts of the organisation and the Charitable Accounts relating to funds held on Trust.

The Audit Committee works with the Finance Committee to ensure overall probity around financial resources within the Trust. The Finance Committee includes some of the members of the Audit Committee. The chair of the Audit Committee, the Finance Committee and the Governance Committee have met periodically throughout 2011/12 financial year to consider areas of joint work and ensure a common understanding and overview by Board members in the management of risk.

The Audit Committee has reviewed the Annual Governance Statement and the Governance Committee and Board of Directors have reviewed the Assurance Framework both of which are part of the framework for managing and mitigating risk for the organisation as a whole. The Committee has endeavoured to gain satisfaction that systems of internal control are in place and potential risks can be identified so that necessary action can be taken to address them.

Charitable Funds Committee

The Committee has reviewed in detail the Charitable Accounts relating to funds held on Trust for the 2010/11 financial year.

External Audit

During the year, the Trust purchased no "non audit services" from the external auditors.

The Audit Committee reviews the independence of the external auditors and considers any material non audit services to ensure independence is maintained.

Fraud

The Trust has an active Internal Audit programme that includes counter fraud as a key element. It participates in national counter fraud initiatives/checks and employs counter fraud specialists to follow up any potential issues identified. A communications strategy has been developed to raise the profile of counter fraud as the responsibility of all staff.

Other Income

The accounts provide detailed disclosures in relation to "other income" where "other income" in the notes to the Accounts is significant. (Significant items are listed in Note 3 to the Accounts).

Audit Information

The directors confirm that so far as they are aware, there is no relevant audit information of which the Company's auditors are unaware and that each director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that the Company's auditors are aware of that information.

Pharmacy technicians in the Sterile Manufacturing Unit preparing nutritional feeds for those patients unable to receive food by mouth.

ANNUAL GOVERNANCE STATEMENT 2011/12

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of City Hospitals Sunderland NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in City Hospitals NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust is committed to a risk management strategy, which minimises risks to patients, staff, the public and other stakeholders through a common framework of internal control, based on an ongoing risk management process.

The strategy identifies the key principles, milestones and operational policies governing the management of all types of risk faced by the organisation. This strategy is subject to regular review.

The Audit Committee meets regularly and is well represented ensuring scrutiny, monitoring, discussion and input. The Finance reports to the Board include reporting on internal Cost Improvement Programmes, which are examined in detail by the Finance Committee. Finance Reports are presented in a format consistent with those submitted to Monitor. During the year the Board risk reporting structures were reviewed. The Governance Committee now leads the work of the Clinical Governance Steering Group and Corporate Governance Steering Group. The Board receives appropriate, timely information and reports from the Governance Committee enabling adequate and appropriate assessment of risk and management of performance.

As part of the on going process of review the Trust's top ten risks (previously adopted by the Board) were scrutinised to ensure that they properly reflected the risks which were identified in the departmental Risk Registers.

The Trust's risk management programme comprises:

- Single incident reporting process for all risks and hazards identified by systematic risk assessment, risk management review and adverse incidents reporting,
- Common grading framework and risk register / risk action planning process applied to all types of risk across the organisation
- Comprehensive programme of multi-level risk management training for all new and existing staff
- Ongoing monitoring and review of both internal and external risk management performance indicators at all levels across the organisation
- A communication strategy which ensures appropriate levels of communication and consultation with both internal and external stakeholders.

4.The risk and control framework

The Trust's framework:

- Identifies the principal objectives of the Trust and the principal risks to achieving them
- Sets out the controls to manage these risks
- Documents assurances about the effectiveness of the operation of the controls
- Identifies to the Board where there are significant control weaknesses and/or lack of assurance.

These high level objectives and the principal risks to achieving them are underpinned by the detailed risks and associated actions set out in the Trust's risk register. Responsibility for the overall Framework lies with the Board of Directors. The Board uses the framework to ensure that the necessary planning and risk management processes are in place to provide assurance that all key risks to compliance with authorisation have been appropriately identified and addressed.

The use of a common grading structure for incidents and risks ensures that relative risks and priorities are assessed consistently across all directorates. No risk is treated as acceptable unless the existing situation complies with relevant guidance and legislation (e.g. Control of Infection, National Patient Safety Agency, Health & Safety, Standing Financial Instructions).

The establishment of a dedicated risk management team and programme of risk management training, including use of the intranet, ensures that the strategy is co-ordinated across the whole organisation and progress is reported effectively to the Board and its risk sub committees.

The Trust's assurance framework incorporates the need to achieve compliance with the Care Quality Commission's requirements.

The assurance framework is based on the Trust's strategic objectives and an analysis of the principal risks to the Trust achieving those objectives. The key controls, which have been put in place to manage the risks, have been documented and the sources of assurance for individual controls have been identified. The main sources of assurance are those relating to internal management controls, the work of internal audit, clinical audit and external audit, and external assessments by outside bodies such as the Care Quality Commission, the NHS Litigation Authority and the Health and Safety Executive.

The assurance framework is cross-referenced with the Board Risk Register.

The involvement of external stakeholders in the Trust's risk management programme is a key element of the Trust's Risk Management Strategy. This involves timely communication and consultation with external stakeholders in respect of all relevant issues as they arise.

This process applies in particular to the involvement of external stakeholders in patient safety and the need to co-ordinate how risks are managed across all agencies, including the National Patient Safety Agency, the Medicines and Healthcare Products Regulatory Agency, Local Authority Adult Services, the Coroner, the emergency services, representative patient groups and local GPs as they form commissioning groups.

The risk to data security is being managed and controlled through the monthly Information Governance Group, with quarterly updates to Corporate Governance Steering Group. The Information Governance Toolkit assessments are conducted as required, and an annual report is produced confirming the outcome in readiness for the submission by 31 March. This report is presented to Executive Committee, Board of Directors and Board of Governors for approval. For the submission on 31 March 2012, all IG requirements were assessed at Level 2 and above (1 is not applicable, 22 at Level 2, and 22 at Level 3) which resulted in the Trust being classified as Satisfactory – Green, with a total score of 83%. Internal audit has independently substantiated this assessment.

City Hospitals Sunderland NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The Trust's strategic planning and performance management arrangements ensure that all directorates are fully engaged in the continuous review of business objectives and performance.

The Trust uses an Objectives, Goals, Strategies and Measures (OGSM) framework as its strategic planning tool to provide a cascade process for the Trusts priorities and ensure optimal alignment of Trust resources to deliver its priorities.

Key elements of the Trust's arrangements for ensuring value for money in the delivery of its services are:

- An Annual OGSM planning process, which sets out priorities for the coming business year and reflects the requirements of and feedback from, our major Commissioners and stakeholders.
- Performance management through regular reporting against the key deliverables set out in the Corporate, Directorate and departmental OGSM's and against national and local targets.
- The achievement of efficiency savings through the Trust's cost improvement programmes with regular review by the Trust's Finance Committee.

Given the continuing recession, this year has again been a difficult one for all public sector organisations with the focus on reducing costs. Combined with a need to reduce costs, activity at the hospital has increased significantly during the year, leaving us to balance the need to reduce costs, cope with demand and improve the quality of patient care.

The focus on cost reduction has been led by the Finance Committee which ensures detailed scrutiny of Cost Improvement Programmes as well as gaining an in depth knowledge of the underlying financial position of the Trust. Financial information by service line was reported quarterly to the Committee and the whole Board.

Patient level costing was again improved giving us detailed knowledge of our costs down to individual patients. The Executive Committee, the Board of Directors and Board of Governors are actively involved in the business planning and performance management processes established by the Trust and in maintaining strong links with stakeholders.

During 2011/12 the Trust has:

- Opened its new ward block which includes a world class Integrated Critical Care Unit as well as a dedicated stroke ward.
- Opened a new Urology treatment centre.
- Planned for a new information system which will come on stream in 2012/13.
- Continued the work on planning for a new A&E department.
- Further increased the resources of the lean team and embedded the lean process into the operational management of the Trust.

Additional assurance in respect of the Trust's arrangements for ensuring economy, efficiency and effectiveness in the use of resources is provided to the Board of Directors through the conduct of regular reviews undertaken by Internal Audit and by External audit work undertaken in accordance with the Audit Code.

6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Over the past year, the Clinical Governance Steering Group has reviewed progress against a range of 'quality' issues on a regular basis. This group, the data previously reported and external reports (eg national clinical audits, peer reviews etc) have shaped our clinical quality improvement plans. The group has also reviewed trends and themes in relation to incidents, complaints and litigation and used the data to inform quality improvement of services.

The Clinical Governance Steering Group as our key group for the monitoring of clinical quality, provides reports to the Governance Committee which in turn is a sub committee of the Board. The Governance Committee receives these reports which provide assurance or highlight any risks to quality. The Corporate Governance Steering Group in parallel to the Clinical Governance Steering Group reports to the Governance Committee on any non-clinical risks or quality issues eg in facilities. In turn, risks to quality identified through these mechanisms, are escalated through to the Board.

Quality Report metrics are also regularly reported throughout the year to the Board of Directors and Executive Committee. These indicators are all reported (along with a number of other metrics) as part of the Trust's Corporate Dashboard.

Most of the data used for these metrics is extracted directly from the hospital's information system (HISS). Where applicable, HISS fields have been designed to conform to national data standards so that when the data is extracted it is already in a format consistent with national requirements and coding standards. The data is coded according to the NHS Data Model and Dictionary, which means that any performance indicators based upon this data can be easily prescribed and that the Trust is able to provide data that is both consistent nationally, and fit for purpose.

Internally, standard operating procedures are used consistently by staff involved in the production of the Trust's performance against national, local and internal indicators. This ensures that the process meets the required quality standards and that everyone uses a consistent method to produce an output. Wherever possible, our processes are fully or at least partially automated to make certain that the relevant criteria are used without fail. This also minimises the inherent risk of human error.

Data quality and completeness checks are built into processes to flag any erroneous data items or any other causes for concern, usually as part of the automated process. In addition, further quality assurance checks are performed on the final process outputs to confirm that the performance or activity levels are comparable with previous activity or expected positions. Where applicable, our performance against key indicators is also evaluated against available benchmarking data or peer group information to help understand at the earliest opportunity whether or not the Trust is likely to be an outlier, which in itself may prompt further investigation.

Data samples are checked for accuracy as a matter of course, to ensure that the processes remain accurate and complete, particularly when implementing new indicators.

For most of the data, specific criteria and standards have to be used to calculate performance which is based on national data definitions where appropriate. To further ensure accuracy the report has been reviewed by two separate internal departments, Clinical Governance and Performance Management, both of which are satisfied with the accuracy of the information reported.

In summary, a substantial proportion of the data used as part of this Quality Report has been previously reported to Board of Directors, Clinical Governance Steering Group, and Executive Committee throughout 2011/12 and feedback from these forums has been used to set future priorities. These arrangements have ensured that a balanced view on quality can be provided through the Quality Report for 2011/12.

With respect to setting the priorities for 2012/13 a wide consultation exercise has been undertaken. Consultation has taken place with the Clinical Governance Steering Group, Board of Governors, Board of Directors, local commissioners, Sunderland LINk and the Health and Wellbeing Scrutiny Committee to ensure that the Quality Report includes views from key stakeholders

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board and its committees have a key role in maintaining and reviewing the effectiveness of the system of internal control.

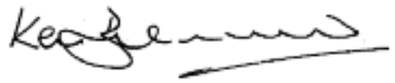
The Executive Committee and Board of Directors have received regular reports on the development of the Trust's risk management framework, in particular through the work of the Governance Committee, Clinical Governance Steering Group and Corporate Governance Steering Group. The Governance Committee receives the minutes of the Clinical Governance Steering Group and Corporate Governance Steering Group and coordinates the implementation of action plans through the Trust's risk register mechanism.

The Finance Committee have again played an important scrutiny role and helped to ensure that efficiency plans are delivered.

The outcome of internal audit reviews has been considered throughout the year through regular reports to the Audit Committee. The Board of Directors receives and considers the minutes of the Audit Committee.

8. Conclusion

My review confirms that no significant internal control issues have been identified.



K W BREMNER
Chief Executive Date: 29 May 2012

REMUNERATION REPORT

The Remuneration Committee for the Chief Executive and Executive Directors is chaired by the Vice Chairman of the Trust. Other members include two Non Executive Directors and the Chief Executive. Membership of the Committee and attendance at the meetings is identified on page 133 of the report. The Chief Executive is not part of the deliberation in relation to his performance or remuneration but joins the committee after this has taken place. The Director of Human Resources attends in an advisory capacity.

In determining the remuneration levels a range of benchmarking evidence is used including:

- NHS-wide governance ie Pay and Contractual Arrangements for NHS Chief Executives and Directors.
- Local comparisons from other Trusts (where information is shared).
- Posts advertised.
- Salary survey for NHS Chief Executives and Executive Directors.

City Hospital's information is benchmarked against the salary for the relevant individuals and recommendations based thereon. To enable the Trust to recruit and retain staff of the highest calibre, salaries are normally linked to the upper quartile of the benchmarks.

The Chief Executive and Executive Directors are on permanent contracts with notice periods that range from 3-12 months.

Each Executive Director and the Chief Executive have annual performance plans against which they are assessed on a mid-year and then end-of-year basis. Whilst their salary is not strictly performance related, the Remuneration Committee will discuss performance when considering any changes to remuneration levels.

Senior Managers' remuneration and pension benefits are detailed in the tables on pages 144 to 146. Accounting policies for pensions and other retirement benefits are set out in note 1.4 to the accounts. No compensation for loss of office paid or receivable has been made under the terms of an approved Compensation Scheme. This is the only audited part of the remuneration report.

K W BREMNER
Chief Executive

Date: 29 May 2012

Salary Entitlements of Senior Managers – 2011/2012

	Age	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Golden Hello/ Compensation for loss of office
		£000	£000	£000
MR K W BREMNER Chief Executive	51	(215-220)		
MRS B J AKEHURST Director of Nursing (Commenced July 4th 2011)	51	(85-90)		
MR L H BOOBIS Medical Director	61	(135-140)		
MRS J PATTISON Director of Finance	45	(145-150)		
DR M SMITH Chief Operating Officer	49	(145-150)		
MR J N ANDERSON Chairman	66	(50-55)		
MR B CHARLTON Non Executive Director (Retired September 30th 2011)	67	(5-10)		
MR D CLIFFORD Non Executive Director	71	(15-20)		
MR M DAVISON Non Executive Director	65	(15-20)		
MS M HARTE Non Executive Director	51	(15-20)		
MR S HINDMARSH Non Executive Director	57	(0-5)		
MR R N NEVILLE Non Executive Director	72	(15-20)		
MR D C BARNES "Shadow" Non Executive Director	66	(0 – 5)		

Plus lease cars (excluding Chairman & Non Executive Directors). Car allowances are between £7-11k per individual. Where car allowances are paid, this is included in the salary band above.

Directors Remuneration Review

	2011/2012	2010/2011
Band of Highest Paid Director's Total Remuneration (£ '000)	215 – 220	215 – 220
Median Total Remuneration (£)	21,869	21,761
Ratio	9.95	9.99

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. In this disclosure the median remuneration has been derived using the cumulative gross pay for all directly employed staff, including those staff employed on flexi-bank contracts and payments to other NHS bodies for staff that perform services for the Foundation Trust. The median remuneration calculation has not been adjusted to 'annualise' part year starters and leavers gross pay as it has been assumed that vacant posts have been recruited to. The banded remuneration of the highest paid director in the Foundation Trust in the financial year 2011/12 was £215k to £220k (2010/11, £215k to £220k). This was 9.95 times (2010/11, 9.99) the median remuneration of the workforce, which was £21,869 (2010/11, £21,761). In 2011/12, 2 employees received remuneration in excess of the highest-paid director (2010/11, 2). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension Entitlements of Senior Managers – 2011/2012

Name and Title	Real increase / (decrease) in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real Increase in CETV	Employers Contribution to Stakeholder Pension
	(bands of £2,500)	(bands of £5,000)				
	£000	£000	£000	£000	£000	£000
MR K W BREMNER Chief Executive	(12.5) – (10.0)	295.0 - 300.0	1,375	1,265	70	0
MRS J PATTISON Director of Finance	35.0 – 37.5	170.0 – 175.0	682	450	219	0
MRS B J AKEHURST Director of Nursing	15.0 – 17.5	95.0 – 100.0	448	315	92	0
DR M SMITH Chief Operating Officer	7.5 – 10.0	150.0 – 155.0	675	549	109	0

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005-06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (Consumer Price Index), contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The Real Increases in Pension and CETV's for Mrs B. J. Akehurst are pro rata to reflect the number of days she was employed by the Foundation Trust in 2011/12.

Independent Auditors' Statement to the Board of Governors of City Hospitals Sunderland NHS Foundation Trust

We have examined the summary financial statement for the year ended 31 March 2012 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity, the related notes and the information in the Remuneration Report that is described as having been audited.

Respective Responsibilities of Directors and Auditors

The directors are responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements and the Directors' Remuneration Report and its compliance with the relevant requirements of the directions issued by Monitor.

We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

This statement, including the opinion, has been prepared for, and only for, the Board of Governors of City Hospitals Sunderland NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and for no other purpose. We do not, in giving this information, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our audit opinion on those financial statements, the Directors' Report and the Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements and the Remuneration Report of City Hospitals Sunderland NHS Foundation Trust for the year ended 31 March 2012 and complies with the relevant requirements of the directions issued by Monitor.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Newcastle upon Tyne 30 May 2012

Directors' Statement

The auditors have issued unqualified reports on the full annual financial statements; the part of the directors' remuneration report that is described as having been audited; and on the consistency of the directors' report with those annual financial statements.

BOARD OF GOVERNORS 2011/12

Composition of the Board of Governors

The Board of Governors of the City Hospitals Sunderland NHS Foundation Trust comprises seven public Governors for Sunderland and two public Governors for the North East, two patient Governors and five staff Governors. It also includes stakeholder representatives from South of Tyne & Wear Primary Care Trust and the City of Sunderland. The Board of Governors is chaired by Mr J N Anderson, Chairman of the Trust.

In accordance with the recently published document, "Your Statutory Duties: A Reference Guide for NHSFT Governors", Mr Ian Tunnicliffe was elected by the Governors in January 2010 and subsequently following Governor elections in June 2010 to be Lead Governor.

Patients Constituency:

From 1 July 2010

Duncan Stephen

Alex Marshall

Public Constituency **North East:**

From 1 July 2010

Yvonne Johnson

Wendy Westmorland

Patients Constituency **Sunderland:** From 1 July 2010

Stephen Blenkinsop

Wilfred Curry

Sara Lake

Ivy Lemmon[1]

Michael McNulty

Susan Pinder

Ian Tunnicliffe

[1] Ivy Lemmon sadly died in December 2011

Staff Constituency **Clinical Class:**

From 1 July 2010

Suzanne Cooper

David McNicholas

Staff Constituency **Medical:**

From 1 July 2010

Shahid Junejo

Appointed Governors **City of Sunderland:**

From June 2011 until May 2012

Councillor David Allan
(Cabinet Member with Portfolio for Health and Social Care)

Staff Constituency **Other:**

From 1 July 2010

Mandy Bates

Mary Pollard

Appointed Governors **Sunderland Primary Care Trust:**

From March 2008 until December 2011

David Barnes
(Non Executive Director)

Meetings of the Board of Governors

Governor	Constituencies	Number of Meetings	Actual Attendance
Alex Marshall	Patient	6	6
Duncan Stephen	Patient	6	5
Stephen Blenkinsop	Public – Sunderland	6	5
Wilfred Curry	Public – Sunderland	6	6
Sara Lake	Public – Sunderland	6	5
Ivy Lemmon[1]	Public – Sunderland	4	3
Michael McNulty	Public – Sunderland	6	6
Susan Pinder	Public – Sunderland	6	6
Ian Tunnicliffe	Public – Sunderland	6	6
Yvonne Johnson	Public – North East	6	4
Wendy Westmorland	Public – North East	6	6
Mandy Bates	Staff – Other	6	5
Mary Pollard	Staff – Other	6	6
Suzanne Cooper	Staff – Clinical	6	5
Dave McNicholas	Staff – Clinical	6	5
Shahid Junejo	Staff – Medical & Dental	6	4
David Barnes[2]	Appointed – South of Tyne & Wear PCT	5	4
Cllr Mel Speding[3]	Appointed – City of Sunderland	1	0
Cllr David Allan[4]	Appointed – City of Sunderland	5	3
John N Anderson	Chairman	6	5
Carol Harries	Trust Secretary	6	6
The following Directors have attended a number of Governor meetings:			
Ken Bremner	Chief Executive		6
Joy Akehurst	Director		3
Les Boobis	Director		3
Julia Pattison	Director		2
Mark Smith	Director		2
Bryan Charlton	Non Executive Director		2
David Clifford	Non Executive Director		2
Mike Davison	Non Executive Director		1
Miriam Harte	Non Executive Director		1
Roy Neville	Non Executive Director		2

[1] Sadly died December 2011.

[2] Resigned from Sunderland PCT in December 2011 following appointment as 'Shadow' Non Executive Director with CHS from January 2012.

[3] Stood down in May 2011 following appointment as Cabinet Secretary of the City of Sunderland.

[4] Appointed from June 2011.

Throughout the year a number of joint workshops have also been held for both the Board of Directors and the Board of Governors so that Non Executive Directors in particular are able to understand the views of Governors and members.

Governor Involvement

Key areas where the Board of Governors have been involved during 2011/12 have included:

- input into our Annual Plan;
- involvement in our Patient Environment Action Team inspections;
- the awarding of the external audit contract;
- assuring themselves of the Trust's overall approach to reduce the level of Hospital Acquired Infection;
- assuring themselves of the Trust's approach to eliminating mixed sex accommodation;
- contributing to the Trust's approach to Clinical Governance;
- assuring themselves of the Trust's approach to Information Governance;
- giving their views on the Trust's approach to Patient and Public Involvement;
- participating in the work of the Community Panel as identified on page;
- involvement in the city-wide Maternity Services Liaison Committee;
- involvement in the Trust's approach to Organ Donation;
- involvement in the Cancer Peer Review assessment;
- assuring themselves of the actions taken as a result of real time patient feedback; and
- appointing new Non Executive Directors.

Register of Interests

A Register of Interests for the Board of Governors is maintained by the Trust Secretary. The format of this register was agreed by the Board of Governors in August 2004. The register is available for inspection by members of the public via application to the Trust Secretary.

Sue Hansford, Employee of the Year for G4S who provide domestic services to the Trust.

MEMBERSHIP

The Foundation Membership Community

The Trust's Membership Community is made up of local residents, patients, carers and staff. Its Membership Community structure comprises four constituencies. Members may join the appropriate constituency depending on the eligibility criteria as outlined below. People who are eligible to become a member of the Community as a whole are:

- over 16;
- a member of City Hospitals Sunderland staff; or
- living in the electoral wards of Sunderland or the North East of England; or
- a registered patient of the Trust since 1 January 2003 (or carer of such patient).

Public Constituencies

Any member of the public living in Sunderland or the North East electoral wards may become a member of the Public Constituency (Sunderland) or the Public Constituency (North East). Staff living in these areas will remain in the Staff Constituency. Members of the public living in these areas will remain in the Public Constituency in preference to the Patients' Constituency.

Patients' Constituency

The Patients' Constituency consists of patients registered with the Trust on or after 1 January 2003 (or carer of such patient) who have been invited by the Trust to become a member of the patients' constituency and therefore become a member without an application being made unless he/she does not wish to do so. Staff who are patients and live outside Sunderland and the North East will remain in the staff constituency.

Staff Constituency

There are three classes within this constituency, namely Medical and Dental, Clinical and Other. Staff who are patients and live outside Sunderland and the North East will remain in the Staff Constituency. Staff who have worked for the Trust for 12 months automatically become members of the Staff Constituency with the provision that they may choose to opt out. Members of the Staff Constituency can also include workers who are not directly employed by the Trust but who exercise functions for the purpose of the Trust. These members need to opt in. Staff are removed from the Staff Constituency when they leave the Trust but are invited to transfer their membership to another constituency provided they meet the eligibility criteria.

Assessment of the Membership

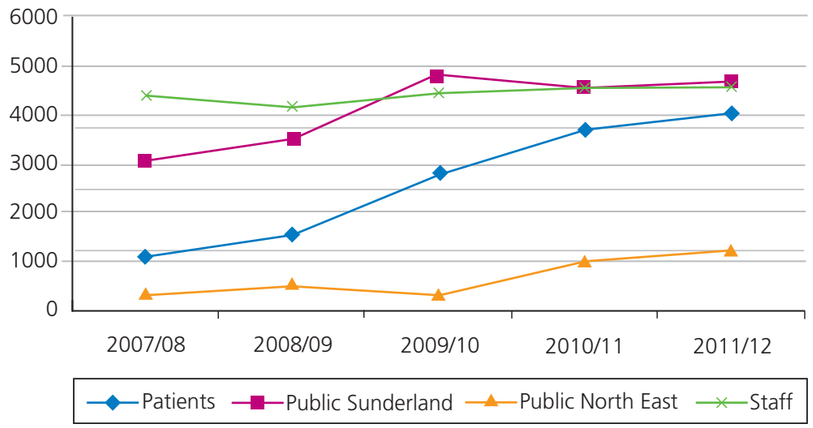
The membership figures for each of the constituencies and classes are given in the Chart below:

Constituency/ Class	Membership 2007/08	Membership 2008/09	Membership 2009/10	Membership 2010/11	Membership 2011/12
Patients	1091	1585	2810	3677	4029
Public[1] (Sunderland)	3058	3502	4778	4533	4639
Public[2] (North East)	346	545	310	1020	1231
Staff					
Medical and Dental	343	321	300	299	305
Clinical	1820	1714	1946	2007	2019
Other	2220	2101	2223	2264	2191
Total	**8878**	**9768**	**12367**	**13800**	**14414**

[1] Residents of the electoral wards of Sunderland Council.

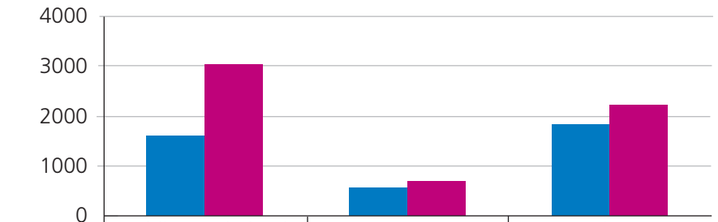
[2] Residents of the electoral wards of the North East of England.

Membership Growth



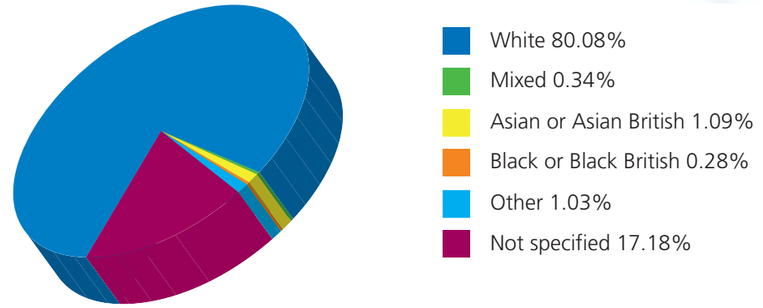
Public Membership

The following information illustrates the composition of the 5870 public members and the 4029 patient members.

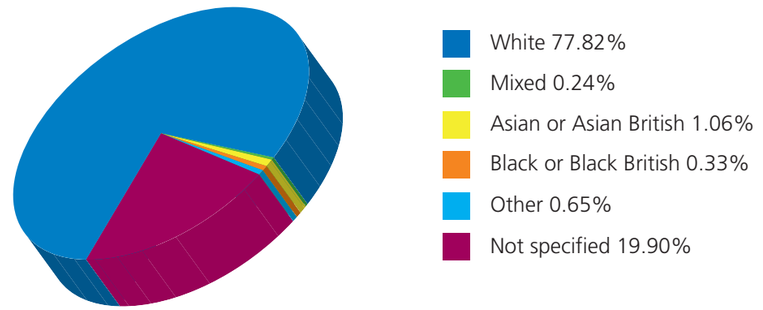


	Public Sunderland	Public North East	Patients
Male	1605	543	1827
Female	3034	688	2202

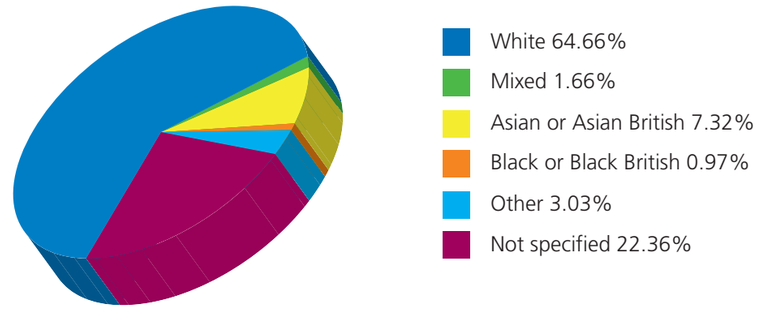
Ethnicity:
Public Sunderland



Ethnicity:
Public North East



Ethnicity:
Patients



Age Profile

Age	Public Sunderland	Public North East	Patients
0 to 16 years	0	0	1
17 – 21 years	39	22	170
22+ years	2479	954	3,187
Not stated	2121	255	671
	4639	1231	4029

Membership Strategy Summary

The Trust has an on-line membership database which has ensured that the database is more accurate. It also allows us to target individual age groups and geographical areas where membership is low by giving generic addresses so that we may write to households identifying the benefits of membership.

The Trust achieved its targets this year for recruiting new members in both the public and patient constituencies.

Mechanisms continue to exist for members of the public to join the Trust and these include:

- Active recruitment of members by our Governors;
- Membership forms located in GP surgeries, City Libraries, AgeUK and the Carers Centre;
- Electronic membership form on the Trust website; and
- A membership form is included with:
  - Clinical Governance patient surveys
  - "Your Stay in Hospital" booklet
  - The Sunderland Partnership's document, "Your Community…..Your say".

Ensuring a Representative Membership

The Trust has a local population of 350,000 with a relatively small ethnic population (The Office of National Statistics identifies a population of 2.25%). Historically within the City engagement with the Health and Social Care Sector has been relatively poor although the development of the city-wide Compact is beginning to identify greater opportunities for engagement.

The city-wide Inclusive Communities group is developing much more meaningful systems of engagement. Despite a number of initiatives however, we still continue to attract a relatively small number of new members from BME groups.

Generally our membership continues to broadly mirror the demographic of the City which has an ageing profile from which it has always been possible to attract members. Whilst we recognise that it is important to grow the membership and to encourage diversity the Trust believes it is more important to ensure that members feel engaged and involved thereby making a real difference within the overall governance arrangements of the Trust.

Communicating with the Membership

If members of the public or patients wish to contact a Governor or Director they can do so in a number of ways:

- at the end of meetings held in public;
- by contacting the Trust Secretary at the address on the back of this report;
- by writing to Governors at the following freepost address:

City Hospitals Sunderland
NHS Foundation Trust
FREEPOST NAT 21669
Sunderland
SR4 7BR

- by accessing the Corporate Affairs inbox address – corporate.affairs@chsft.nhs.uk

PUBLIC INTEREST DISCLOSURES

Consultation and Involvement

The Trust continues to develop the work of the Patient and Public Involvement Committee which is now recognised as a formal sub committee of the Board of Directors. The Committee is chaired by one of our Non Executive Directors and has Governor, Community Panel and the Carers Centre representation.

It provides an overarching framework and approach to involvement and also ensures that the Trust upholds the pledges outlined within the NHS Constitution.

A key area of work during 2011/12 has been the continued development of our real time patient feedback system details of which are outlined on pages 82 to 86. This year the system has been extended and the 'core' questionnaire customised to include the Eye Infirmary and Maternity Services. Real Time feedback has also been introduced in paediatrics where not only the children are asked about their experiences but also their parents or carers views are included.

Work has also been undertaken to develop action plans following the publication of the national inpatient and outpatient surveys.

A key area of work going forward will be the review of the Patient and Public Involvement Strategy which will reflect the Carers' Strategy for Sunderland, currently under development, and also reflect the NICE quality standards for Patient Experience and the NHS Constitution.

The Trust continues to work closely with the Health and Wellbeing Review Committee of the City of Sunderland and ensures attendance at all meetings maintaining a positive relationship with the Committee and alerting to them any significant issues.

The Committee this year chose rehabilitation and early supported discharge to establish how effectively health and social care services are working in partnership to support timely discharges from hospital and promote independence in community settings.

The results of the review are to be submitted to the Local Authority's Cabinet following which an action plan will be developed with colleagues from health and social care across the city to address the key recommendations.

As part of the review the Health and Wellbeing Committee commissioned the Local Improvement Network (LINk) to survey a number of patients who were ready for discharge. The LINk worked closely with the Trust and were given complete access to speak to as many patients as they needed.

The Director of Corporate Affairs continues to attend the core group meeting of the LINk to respond to concerns and highlight particular issues.

The Trust is also an active member of a working group established by the Local Authority to inform and develop the specification for the establishment of the local Healthwatch, the new independent consumer champion for health and social care which will replace the LINk.

Meetings of the Trust's Board of Governors are held in public and members of the public are welcome to attend. The meetings are advertised in the local press and on the internet. A number of regular attendees are mailed papers in advance of any meeting.

Governors and Directors in attendance are available at the end of every meeting to discuss any issues or concerns.

Communication and Consultation with employees has been detailed previously in background information.

Equality and Diversity

The Trust is committed to a policy of equality of opportunity not only in our employment and personnel practices for which we are all responsible, but also in all our services. To ensure that this commitment is put into practice we adopt positive measures which seek to remove barriers to equal opportunity and to eliminate unfair and unlawful direct or indirect discrimination.

This year we have developed our Equality Strategy for 2012-2016 in response to the requirements of the Equality Act 2010 which builds on the previous actions and objectives that were contained in our former Single Equality Scheme. It is also designed to meet the requirements of the Human Rights Act and the new National NHS Equality Delivery System (EDS).

Within the EDS there are four main goals:

- Better health outcomes for all;
- Improved patient access and experience;
- Empowered, engaged and included staff; and
- Inclusive leadership at all levels.

Through the development of the scheme, we will continue to promote equality of opportunity amongst different groups of people and ensure that potentially vulnerable groups and individuals are supported, and their needs are addressed, in ways that are best suited to them.

It is a long term commitment driven by both staff and the new equalities legislation. The Board of Directors is committed to monitoring progress against our objectives and reporting regularly and openly in line with the specific duties of the Equality Act 2010.

We look forward to the work ahead, facing the challenges, and delivering the actions we have set ourselves and ensuring that everyone has the opportunity to be involved in shaping and influencing the decisions and services that affect them and the patients we serve.

As part of our approach we are continuing to pilot our equality and human rights audit tool which has been developed in partnership with the Royal College of Nursing. The tool aims to support staff in identifying best practice standards for achieving dignity and equality in healthcare. A formal evaluation of the tool will be undertaken during 2012/13.

The Trust also aims to develop a working environment and culture in which bullying and harassment are unacceptable and where individuals have the confidence to complain about bullying and harassment should it arise, in the knowledge that their concerns will be dealt with appropriately and fairly.

As a consequence the Trust has launched a new Harassment and Bullying Policy and appointed nine Staff Dignity at Work Advisors. These are "ordinary" employees who have been trained to listen and support other employees in the workplace. They work in a voluntary capacity and meet regularly as a network, co-ordinated by the Trust's Equality and Diversity co-ordinator.

We also continue to work in partnership with the learning disability community within the city to specifically identify issues for people who access healthcare services at our hospitals. Our learning disability patient forum have undertaken two 'mystery shopping' exercises looking at use of the Help Card and staff's awareness of mental capacity and their understanding of Deprivation of Liberty. Members of the forum have presented their survey results to the Patient and Public Involvement Steering Group who will monitor the resulting action plan.

The Trust continues to support the Governments 'two ticks' disability symbol to demonstrate our commitment to ensuring that people with disabilities have full and fair consideration for all vacancies. If employees become disabled during employment we will endeavour to adjust their workplace environment wherever possible to allow them to maximise their potential, and to return to work.

Occupational Health

This winter's influenza vaccination programme was our most successful placing the Trust as one of two top performing NHS Trusts in the region in terms of vaccinating healthcare workers. With the help and support of ward based vaccinators the Trust achieved a 75% compliance rate of those staff who qualified to receive the vaccine under Department of Health guidelines – well above the 60% target set by NHS North East.

Following the success last year of an on site mobile clinic for Employee Eyecare, a second session was held during September 2011. This clinic gave all staff the opportunity to have a free eye test during working hours.

The department has also worked with colleagues in Control of Infection and Health and Safety to develop a new Trust Hand Dermatitis policy which aims to ensure that staff, visitors and patients are protected from adverse reactions to latex products used in the clinical setting.

Security

The Trust's security team came through one of their biggest challenges during 2011/12 in relation to the management of car parking on the Sunderland Royal Hospital site with the ongoing work on the new Jubilee Wing and other enhancements to the site infrastructure.

At the peak of the development, car parking spaces reduced by 30% although vehicle access to the site continued to increase. At times this undoubtedly caused difficulties for both patients and staff and whilst the security team offered help and support with parking there were those individuals who persistently flouted the Traffic Management policy causing potential safety and security risks.

The Trust therefore introduced in November 2011 a new car parking control system after assessing systems in other similar sized organisations, and continuously measuring the volume of traffic and traffic infringements on the hospital site.

The new system aimed to offer improved vehicle access for patients and their visitors, and to reduce the inappropriate parking practices that impact on all those who require access to our site for treatment, or to visit a relative or friend.

Many of our spaces were occupied throughout the day by drivers not actually using any of the hospital services or by drivers without the necessary blue badge validation occupying dedicated disabled bays. The Trust has over 1,300 parking spaces to control across the Sunderland Royal Hospital site and has found it an impossible task to manage manually, without committing significant NHS resource. A partnership agreement was developed with a dedicated car parking company, "Parking Eye" who provided the Trust with all the equipment necessary to monitor parking activity. The Trust however, continues to retain full control over the management of the car parking system and our security team continue to respond and support any associated car parking issues. The control system is also being introduced onto the Sunderland Eye Infirmary and Children's Centre sites later this year having improved the system following lessons learned on the Sunderland Royal hospital site.

During the coming year the team will face more challenges as work beings on our new multi-storey car park and they will be actively involved in ensuring we maintain reasonable access and offer advice and support to those experiencing parking difficulties during the construction period.

Our security team also continue to provide 24/7 cover offering support, advice and assistance to both members of the public and staff. Unfortunately some of the issues involve potentially violent and criminal activities and our relationship with Northumbria police remains critical during these incidents. Our local police continue to provide drop-in clinics on site allowing staff and the public to ask advice about any concerns either at home or at work.

All security activity is recorded and monitored and discussed at our monthly Security Group meetings.

Health and Safety

The Trust has an active Health and Safety group with representatives from a wide range of hospital departments drawn from both staff side and managers. The group meets monthly to facilitate the management of Health and Safety and to ensure actions are in place to reduce the number of operational health and safety risks.

A series of annual milestones are agreed and monitored to ensure that progress is measured on a year on year basis. Key areas of activity include:

- the management of violence and aggression;
- manual handling;
- sharps and needlestick injuries;
- slips, trips and falls;
- the overall management of risk based on the Health and Safety Executive's "Successful Health and Safety Management" guidance document; and
- stress.

Fire Safety

The Trust's strategy for the management of fire safety is influenced by the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum fire safety guidance documents.

We are please to report high levels of staff compliance with fire safety training. Whilst we have seen a reduction in the number of false alarms following completion of the Jubilee Wing, we continue to liaise with the local fire brigade to manage and reduce unwanted fire signals as well as a planned programme of fire safety compliance audits.

Sustainability/Climate Change

Sustainable development is essentially ensuring that we meet the needs of the present without compromising the needs of future generations.

It encompasses social, environmental and economic goals and must consider the long term implications of the decisions we make

It is widely acknowledged that human activity, in particular the burning of fossil fuels is a major contributor to climate change, arguably the largest threat to global health at present. As the largest organisation in the United Kingdom, the NHS is very well placed to set an example in reducing the carbon footprint.

The NHS emits around 18million tonnes of CO^2 annually (Energy – 22%, Transport – 18% and Procurement 60%). Monitoring, measuring and reporting is an important step in becoming a low carbon organisation by challenging and changing behaviours. NHS Trusts are required to have a carbon strategy and to measure and report on carbon arising from the whole health care process.

City Hospitals adheres to the legally binding Kyoto protocol and The Climate Change Act 2008 alongside NHS and governmental guidance including "Saving Carbon, Improving Health". In August 2009 the Trust developed its Carbon Strategy demonstrating our commitment to the health of the environment, our employees and the community we serve whilst also promoting performance transparency.

The Sustainability Management Plan incorporated into the Carbon Strategy and Climate Change Plan focuses on the following ten key areas:

- **Energy and Carbon Management**
  The Trust will review its energy and carbon management at board level, develop better use of renewable energy where feasible, measure and monitor a whole life cycle cost basis and ensure appropriate behaviours are encouraged in individuals as well as across the organisation;
- **Procurement and Food**
  The Trust will consider minimising wastage at the buying stage, work in partnership with suppliers and in particular local suppliers to lower the carbon impact of all aspects of procurement, make decisions based on whole life cycle costs and promote sustainable food throughout its organisation; the Trust continues to use Fairtrade products wherever possible.
- **Travel and Transport**
  We will routinely and systematically review the need for staff, patients and visitors to travel by car, consistently monitor business mileage, provide incentives for low carbon transport and promote care closer to home, telemedicine and home working opportunities;
- **Waste**
  We will endeavour to efficiently monitor, report and set achievable targets on the management of domestic and clinical waste including minimising the creation of waste in medicines, food and reviewing our approach to single use items against decontamination options.

The Trust has a robust approach to recycling, and paper, cardboard, wood, metal, oils, fluorescent tubes, batteries, waste electrical goods and confidential waste are all recycled.

- **Water**
  The Trust will ensure efficient use of water by measuring and monitoring its usage by incorporating waste saving schemes into building developments, by quick operational responses to leaks, by using water efficient technologies and by avoiding the routine purchasing of bottled water.
- **Designing the Built Environment**
  The Trust will aim to address sustainability and low carbon usage in every aspect of the design process and operations. This includes resilience to the effects of climate changes, energy management strategies and a broader approach to sustainability including transport, service delivery and community engagement.
- **Organisational and Workforce Development**
  We will encourage and enable all members of staff to take action in their workplace to reduce carbon. Staff will be supported by promoting increased awareness, encouraging low carbon travel, facilitate home working and ensuring sustainable development is included in every job description.
- **Partnerships and Networks**
  The Trust will continue to consolidate partnership working and in particular contribute to the city wide sustainable development approach overseen by the Local Strategic Partnership Board.
- **Governance**
  The Trust will adhere to the Good Corporate Citizenship Assessment Model and produce a board approved Sustainable Development Management Action Plan, whilst also setting interim targets to meet the provisions of the Climate Change Act 2008.
- **Finance**
  The Trust will ensure appropriate investment to meet the commitments required to become part of a low carbon NHS and in preparation for a carbon tax regime.

Working in partnership will be essential to deliver relevant incentives, economies and training to support the shift in culture for the local economy.

Carbon Reduction Schemes

CRC

The Carbon Reduction Commitment Energy Efficiency Scheme (CRC) is a mandatory carbon emissions reporting and pricing scheme to cover organisations using more than 6,000 MWh per year of half hourly metered electricity.

The CRC came into force in 2010 and aims to cut carbon emissions not covered by other pieces of legislation. Initially promoted as a carbon reduction mechanism with a recycling fund attached the CRC has now changed to become a tax on carbon. The Trust is required to report its carbon emissions annually. The footprint report and first annual report was submitted in July 2011. Emissions for the first year were 9,900 tonnes of carbon.

EUETS

The CRC complements the EUETS (European Emissions Trading System) which commenced in 2005 and is the largest multi country and multidisciplinary greenhouse gas trading system in the world. It is one of the policies introduced across the EU to help meet carbon reduction targets under the Kyoto protocol, which includes an 8% reduction in C02 on 1990 levels by 2012.

City Hospitals is currently in Phase II of the scheme which runs from 2008–2012 and successfully completed the verification process for last year running from 1 January 2011 to 31 December 2011. Emissions for 2011 were 10,137 tonnes of carbon and have reduced by 870 tonnes on last year's figures.

Energy Conservation

The Trust has employed a number of measures to reduce our carbon footprint and save energy within the trust. Schemes that have been commissioned and completed in 2011/12 include lighting schemes with automatic controls and building management system controller and plant room upgrades. Possible future projects range from Waste to Water (diversion of food waste into drains), LED technology, solar panels, absorption chillers and Biomass heating systems, which all encourage further reductions in our carbon footprint and continual improvement in environmental performance.

Waste Minimisation

As part of our Sustainable Development Management Plan and Carbon Reduction Strategy, co mingled recycling is currently being successfully employed across the Trust. In-line with legislation, a new offensive waste stream trial has also been introduced, set to significantly reduce disposal costs.

Utilities

- **Water**
  Usage has risen due to an increase in business and patient throughput, clean hands initiative and a domestic hot water flushing regime to assist with the control of infection.
- **Electricity**
  Usage has been comparable with last year but unit price cost has increased.
- **Gas**
  Consumption of gas has been lower than the previous year aided by the mild winter and the replacement of some of the older estate with more energy efficient buildings. Cost per unit has increased by 10%.

Targets for Carbon Reduction Strategy and Climate Change Plan

In line with the Climate Change Act 2008, the NHS is required to reduce is carbon emissions by 10% by 2015. The target for 2050 is a reduction of 80%.

The Sustainable Development Unit suggests carbon reduction targets for the following by 2015;

- Energy (an increase in energy from renewables by 10% from 2007 by 2015);
- Buildings (a reduction of 10% from 2007 baseline by 2015);
- Waste (an increase in recycling by 20% by 2015 from 2007 levels and a reduction in both clinical waste and domestic waste of 10%);
- Water (a reduction in water usage including borehole water of 10% by 2015); and
- Travel (a carbon reduction from NHS travel of 20% by 2015).

Fraud

The Trust has an active internal audit programme that includes counter fraud as a key element. It participates in national counter fraud initiatives/checks and employs counter fraud specialists to raise awareness and follow up any potential issues identified. One of our Non Executive Directors has also been appointed as "Counter Fraud Champion".

Jacqueline Mains, Infection Prevention and Control Matron.

DIRECTORS' REPORT

The Companies Act 1995 requires the company to set out in this report a fair review of the business of the Trust during the financial year ended 31 March 2012 including an analysis of the position of the Trust at the end of the financial year and a description of the principal risks and uncertainties facing the Trust.

Business Review

The information which fulfils the business review requirements can be found in the following sections of the Annual Report which are incorporated into this report by reference:

- Chairman's statement on page 6
- Chief Executive's statement on page 8
- Operating and Financial Review on pages 13-123
- Public Interest Disclosures on pages 157-162

The Trust has complied with all relevant guidance relating to the better payment practice code, calculation of management costs and declaration of the number and average pension liabilities for individuals who have retired early on ill health grounds during the year. The relevant declarations are detailed in the Annual Accounts.

This section together with the sections of the Annual Report incorporated by reference constitutes the Director's report that has been drawn up and presented in accordance with the guidance in the Foundation Trust Annual Reporting Manual (FT ARM).

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator NHS Foundation Trusts ("Monitor").

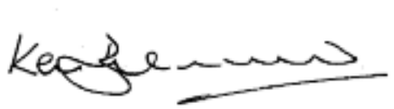
Under the National Health Service Act 2006, Monitor has directed the City Hospitals Sunderland NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accrual basis and must give a true and fair view of the state of affairs of City Hospitals Sunderland NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



K W BREMNER
Chief Executive

Date: 29 May 2012

Summarised Financial Statements

(a full copy of the annual accounts is available upon request)

Statement of Comprehensive Income for the Year Ended 31st March 2012

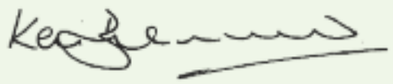
	2011/12 £000	2010/11 Restated £000
INCOME	306,021	293,974
EXCEPTIONAL INCOME	0	744
OPERATING INCOME	306,021	294,718
OPERATING EXPENSES	(295,614)	(285,350)
OPERATING SURPLUS	**10,407**	**9,368**
FINANCE INCOME	123	120
FINANCE EXPENSE	(1,382)	(1,372)
PUBLIC DIVIDEND CAPITAL DIVIDENDS PAYABLE	(5,365)	(5,216)
NET FINANCE COSTS	**(6,624)**	**(6,468)**
SURPLUS/(DEFICIT) FOR THE YEAR	**3,783**	**2900**
OTHER COMPREHENSIVE INCOME:		
REVALUATION GAINS AND IMPAIRMENT LOSSES OF PROPERTY, PLANT AND EQUIPMENT	0	2,969
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR	**3,783**	**5,869**

There is a change in accounting policy in 2011/2012 with respect to the treatment of Donated Assets. This change has required the restatement of the 2010/2011 accounts. The change requires Donated Asset income to be fully recognised in the Statement of Comprehensive Income in the year that the asset is purchased whereas previously this would have been shown against the Donated Asset Reserve (which now no longer exists) on the Statement of Financial Position.

Statement of Financial Position as at 31st March 2012

		31 March 2011 £000	31 March 2011 £000 Restated	1 April 2010 £000 Restated
NON CURRENT ASSETS		205,374	207,258	190,885
CURRENT ASSETS	INVENTORIES	3,651	3,592	3,140
	TRADE AND OTHER RECEIVABLES	10,548	5,834	10,182
	CASH AND CASH EQUIVALENTS	19,951	18,571	17,149
TOTAL CURRENT ASSETS		34,150	27,997	30,471
CURRENT LIABILITIES		(30,004)	(27,573)	(23,163)
TOTAL ASSETS LESS CURRENT LIABILITIES		209,520	207,682	198,193
NON CURRENT LIABILITIES		(35,208)	(37,153)	(33,029)
TOTAL ASSETS EMPLOYED		**174,312**	**170,529**	**165,164**
FINANCED BY:	TAXPAYERS' EQUITY			
	PUBLIC DIVIDEND CAPITAL	98,681	98,681	99,158
	REVALUATION RESERVE	71,415	71,415	68,473
	INCOME AND EXPENDITURE RESERVE	4,216	433	(2,467)
TOTAL TAXPAYERS' EQUITY		**174,312**	**170,529**	**165,164**

The financial statements were approved by the Board on 29 May 2012 and signed on its behalf by:



K W BREMNER
Chief Executive

Date: 29 May 2012

Statement of Changes in Taxpayers Equity

	TOTAL £000	PDC £000	REVALUATION RESERVE £000	DONATED ASSET RESERVE £000	INCOME & EXPENDITURE RESERVE £000
1 APRIL 2011	**170,529**	**98,681**	**71,415**	**0**	**433**
RETAINED SURPLUS FOR THE YEAR	3,783	0	0	0	3,783
31 MARCH 2012	**174,312**	**98,681**	**71,415**	**0**	**4,216**
1 APRIL 2010	**165,164**	**99,158**	**68,473**	**1,684**	**(4,151)**
PRIOR PERIOD ADJUSTMENT	0	0	0	(1,684)	1,684
1 APRIL 2010 RESTATED	**165,164**	**99,158**	**68,473**	**0**	**(2,467)**
RETAINED SURPLUS FOR THE YEAR	2,900	0	0	0	2,900
REVALUATION LOSSES	3,686	0	3,686	0	0
OTHER RESERVE MOVEMENTS	(1,221)	(477)	(744)	0	0
31 MARCH 2011	**170,529**	**98,681**	**71,415**	**0**	**433**

Statement of Cashflows for the Year Ended 31st March 2012

	2011/12 £000	2010/11 Restated £000
CASHFLOWS FROM OPERATING ACTIVITIES		
OPERATING SURPLUS FROM CONTINUING OPERATIONS	10,407	9,368
NON CASH INCOME AND EXPENSE:		
DEPRECIATION & AMORTISATION	8,131	7,614
(INCREASE)/DECREASE IN TRADE & OTHER RECEIVABLES	(4,696)	4,170
INCREASE IN INVENTORIES	(59)	(452)
INCREASE IN TRADE & OTHER PAYABLES	3,312	4,080
(DECREASE)/INCREASE IN PROVISIONS	(74)	267
OTHER MOVEMENTS IN OPERATING CASH FLOWS	64	(1,221)
NET CASH INFLOWS FROM OPERATING ACTIVITIES	**17,085**	**23,826**
NET CASH OUTFLOWS FROM INVESTING ACTIVIES	**(7,909)**	**(19,667)**
NET CASH INFLOWS (OUTFLOWS) BEFORE FINANCING	**9,176**	**4,159**
CASHFLOWS FROM FINANCING ACTIVITIES		
LOANS RECEIVED	0	3,490
LOANS REPAID	(1,024)	(430)
INTEREST PAID	(1,360)	(1,105)
PDC DIVIDEND PAID	(5,412)	(4,692)
NET CASH INFLOWS / (OUTFLOWS) FROM FINANCING ACTIVITIES	**(7,796)**	**(2,737)**
INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**1,380**	**1,422**
CASH AND CASH EQUIVALENTS AT 1 APRIL	**18,571**	**17,149**
CASH AND CASH EQUIVALENTS AT 31 MARCH	**19,951**	**18,571**

Glossary

A

ACP	Advance Care Plan
AMU	Acute Medical Unit
ASU	Acute Stroke Unit

B

BSR	British Society of Rheumatology
BTS	British Thoracic Society

C

CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile infections
CEMACH	Confidential Enquiry into Maternal and Child Health
CETV	Cash Equivalent Transfer Value
CHKS	Caspe Healthcare Knowledge System
CHP	Combined Heat and Power
CIP	Cost Improvement Programme
COPD	Chronic Obstructive Pulmonary Disease
CPA	Clinical Pathology Accreditation
CPAU	Chest Pain Assessment Unit
CPI	Consumer Prices Index
CQUIN	Commissioning for Quality and Innovation
CQC	Care Quality Commission
CRC	Carbon Reduction Commitment
CSRT	Community Stroke Rehabilitation Team

D

DAHNO	Data for Head and Neck Oncology
DIPC	Director of Infection Prevention and Control
DNA	Did not Attend
DOSA	Day of Surgery Admission

E

E.Coli	Escherichia coli
EBUS – TBNA	Endobronchial Ultrasound – Transbronchial Needle Aspiration
EIA	Equality Impact Assessment
EPUAP	European Pressure Ulcer Advisory Panel
EUETS	European Emissions Trading System
EWS	Early Warning System

F

FT ARM	Foundation Trust Annual Reporting Manual
FTFF	Foundation Trust Financing Facility
FTSE 100	Share Index of the 100 most highly capitalised UK companies listed on the London Stock Exchange

G

GI	Gastro-intestinal

H

HCAI	Health Care Associated Infection
HISS	Hospital Information Support System
HSMR	Hospital Standardised Mortality Ratio
HRG	Healthcare Resource Group

I

IBD	Inflammatory Bowel Disease
ICCU	Integrated Critical Care Unit
ICNARC	Intensive Care National Audit & Research Centre
IFRS	International Financing Reporting Standards
IG	Information Governance
IV	Internal Validation

J

JAG	Joint Advisory Group
JCG	Joint Consultative Group

L

LCP	Liverpool Care Pathway
LINk	Local Improvement Network
LIPS	Leading Improvements in Patient Safety
LCT	Long Term Conditions
LUCADA	Lung Cancer Data

Glossary

M

MDT	Multi Disciplinary Team
MHRA	Medicines and Healthcare Products Regulatory Agency
MINAP	Myocardial Ischaemia National Audit Project
MMSE	Mini Mental State Examination
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool

N

NCDAH	National Care of the Dying Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Inquiry into Suicide and Homicide by people with Mental Illness
NCPR	National Cancer Peer Review
NHSBT	NHS Blood Transfusion
NHSLA	National Health Service Litigation Authority
NICE	National Institute of Clinical Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NICU	Neonatal Intensive Care Unit
NIHR	National Institute of Health Research
NIV	Non Invasive Ventilation
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency

P

PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
PET CT	Positron Emission Tomography – Computed Tomography
PICA Net	Paediatric Intensive Care Audit Network
POMH	Prescribing Observatory for Mental Health
POWWOW	A meeting of all Practioners involved in a patient's care
PPI	Patient and Public Involvement
PREP	Perioperative Risk Evaluation and Preparation
PROMS	Patient Reported Outcome Measures

Q

QIPP	Quality, Innovation and Improvement

R

RAMI	Risk Adjusted Mortality Index
RCA	Root Cause Analysis
RCOG	Royal College of Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RPIW	Rapid Process Improvement Workshop

S

SA	Self Assessment
SHA	Strategic Health Authority
SHIMI	Summary Hospital level Mortality Index
SINAP	Stroke Improvement National Audit Programme
Six Sigma	A business management strategy developed by Motorola
SLR	Service Line Reporting

T

TIA	Transient Ischaemic Attack
TPOT	The Productive Operating Theatre
T&O	Trauma & Orthopaedics

V

VTE	Venous - thromboembolism

chs

Excellence in Health, putting People first

If you would like a full copy of the Annual Accounts, please contact:

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