City Hospitals Sunderland NHS
NHS Foundation Trust

ANNUAL REPORT

Sunderland Royal Hospital
Kayll Road
Sunderland
Tyne & Wear SR4 7TP

City Hospitals Sunderland NHS
NHS Foundation Trust

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NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2009/2010

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

If you require this information in a different format please contact:

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City Hospitals Sunderland
NHS Foundation Trust

Annual Report & Accounts 09 10

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

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City Hospitals Sunderland
NHS

Year at a Glance

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Inpatients	51,589	53,698	55,749	56,093[1]	57,778	59,565
Daycases	39,153	40,324	44,012	45,942	51,749	53,246
Outpatients (Consultant led – New & Review)	264,399	264,957	289,127	301,009	314,757	314,562[2]
Nurse Led/Allied Health Professional/Midwife Activity	N/A	N/A	N/A	134,568[3]	147,216	157,944
A&E Attendances	114,436	106,603	102,382	101,285	101,292	112,676[4]
Patient Contacts in the Community	212,638	213,741	212,000	233,161	223,644	225,159
Day Care Attendances	9,148	5,844	6,754	3,722	3,282	4,275[5]
Income	£211.05m	£221.65m	£241.22m	£254.52m	£270.24m	£285.64m
Surplus (Deficit)	(£2.690m)	(£4.547m)	£0.184m	£5.678m	£1.583m	£1.219m
Average Staff Employed (Headcount)	5,207	5,163	4,782	4,614	4,863	4,995

Notes:

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

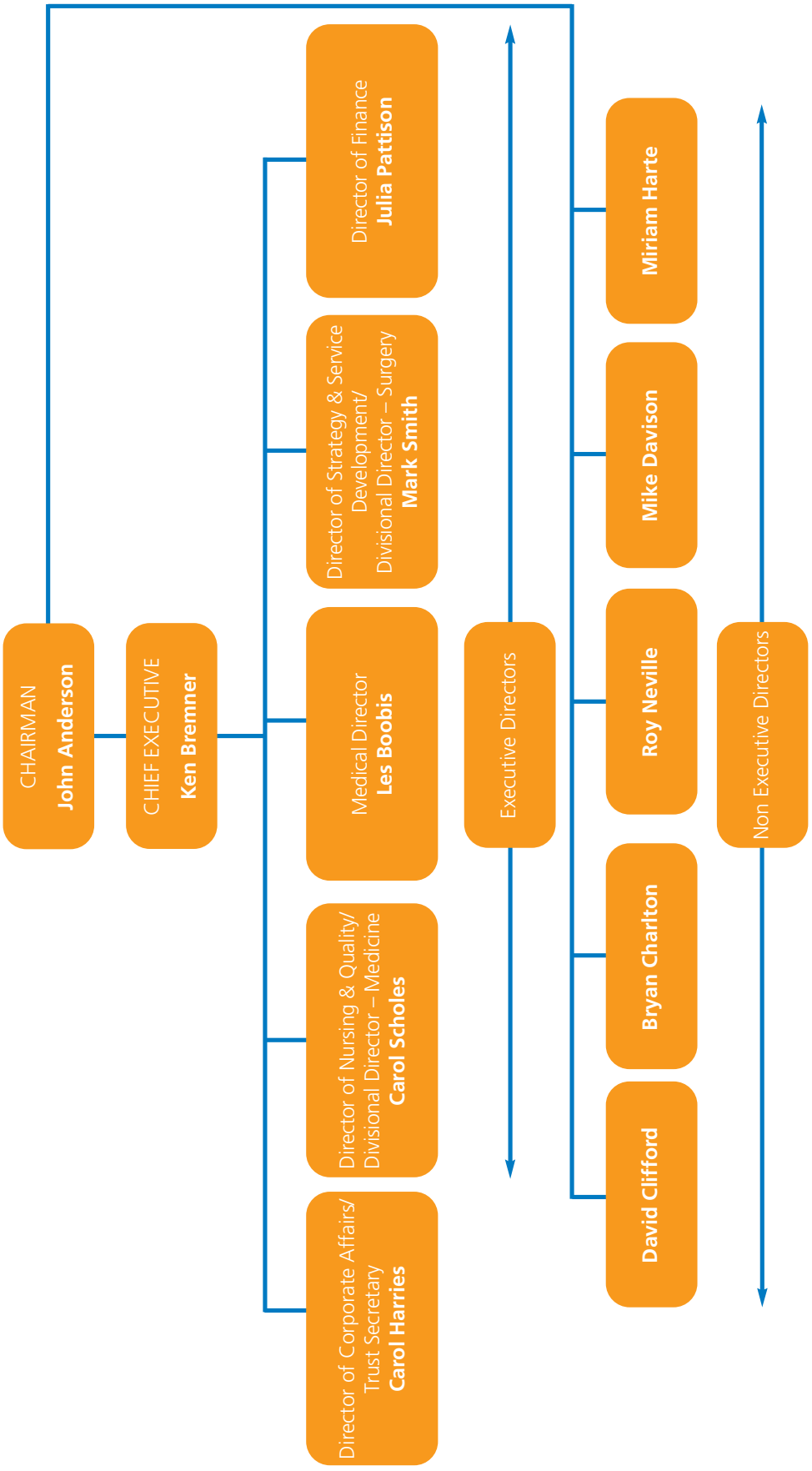
2 The new to review ratio has changed with fewer review outpatient appointments for each new patient in line with national best practice.

3 This figure was captured from 2007/08 onwards to reflect the increasing number of patients seen by nurses/midwives and Allied Health Professionals.

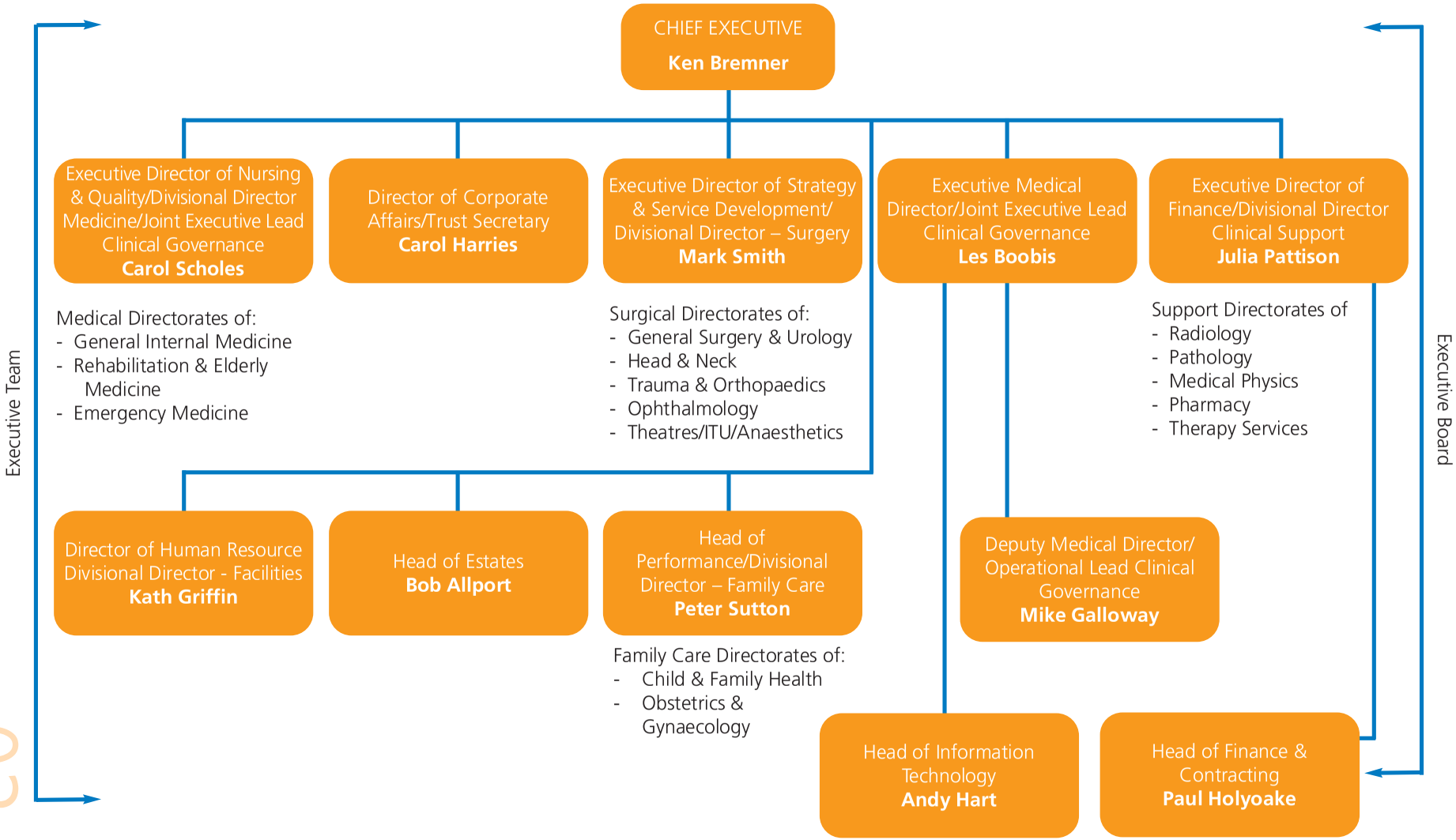
4 Attendances have risen this year despite the continued investment into Primary Care Services and reflect increased activity over a busy and difficult winter period.

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 2009/10



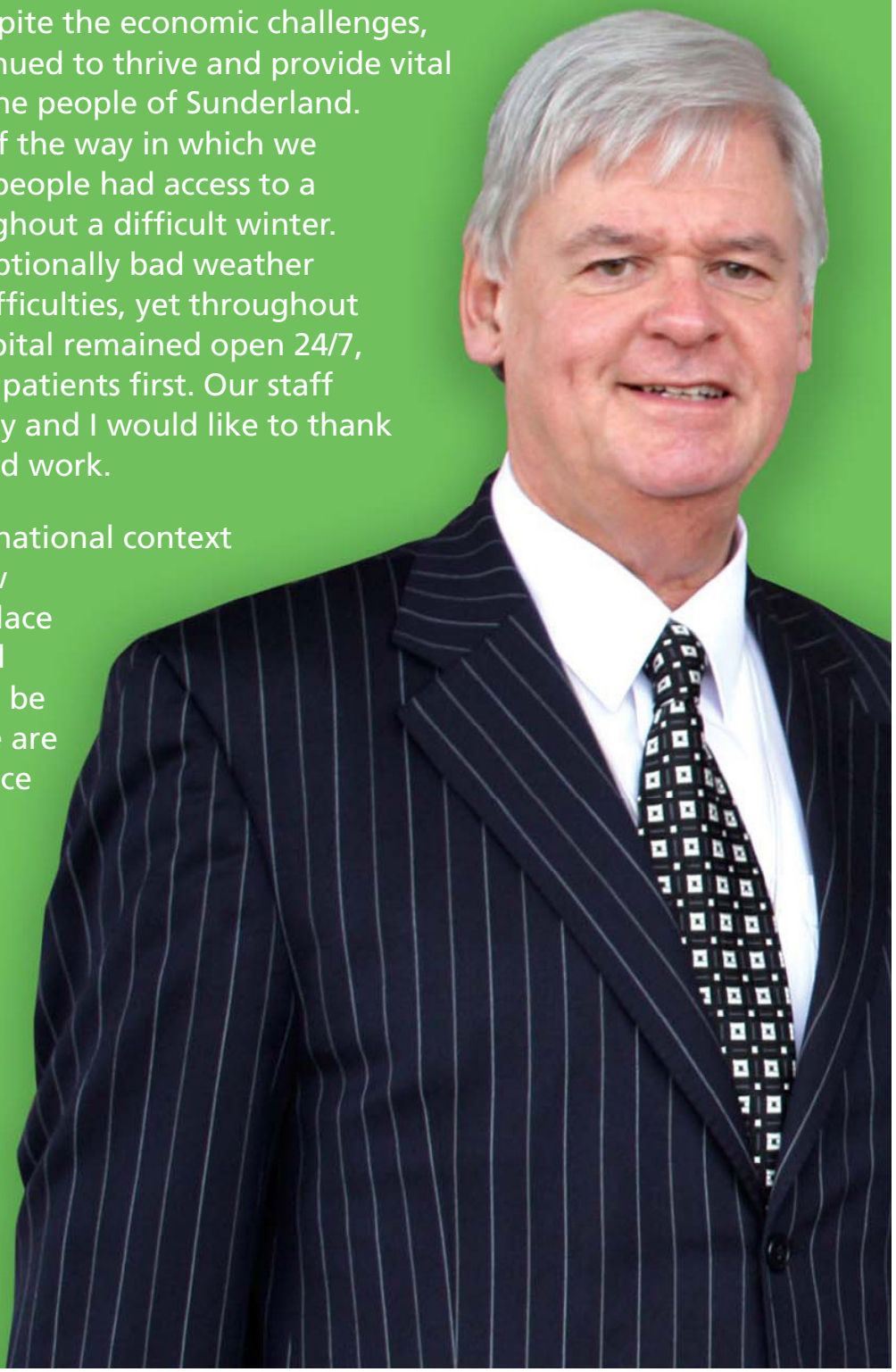
EXECUTIVE TEAM 2009/10



Chairman's Statement

In this, my first full year as Chairman of City Hospitals, I haveoften reflected on the hard work and dedication of all our staff. Despite the economic challenges, this Trust has continued to thrive and provide vital health services to the people of Sunderland. We can be proud of the way in which we ensured that local people had access to a hospital bed throughout a difficult winter. Swine flu and exceptionally bad weather posed us unique difficulties, yet throughout the winter the hospital remained open 24/7, always putting our patients first. Our staff coped tremendously and I would like to thank you all for your hard work.

We know that the national context has changed, a new Government is in place and tough financial decisions remain to be taken. However we are well prepared to face any challenges and will ensure that we remain at the forefront of delivering healthcare services.



It remains vitally important to deliver high quality and safe healthcare for the population we serve, and we need to maintain our high standards and provide every patient and their carer with the best possible hospital experience. I trust that you all will join with me in working toward that goal.

The last year has provided me with an opportunity to work closely with the Board of Directors and the Board of Governors; both these Boards take their responsibilities seriously to make certain that they have assurance about the quality and safety of the services we provide. I am indebted to the Non Executive Directors who provide constructive challenge to ensure that the Board is rigorous in its approach to scrutiny and decision making. I would like to thank both the Board of Directors and the Board of Governors for their support and guidance over the last twelve months. Our Governors in particular, are up for possible re-election this year and I hope that many of them will put themselves forward for another term of office. They receive no salary for their time and commitment but I have continued to be impressed by their willingness to take on new challenges and also the robustness of our discussions. They genuinely want to see that the services we provide are truly excellent.

Last September I was privileged to attend my first Reward and Recognition event at the Stadium of Light. This was a tremendous evening and showcased the very best that the Trust offers in terms of patient care, partnership working and key individual and team achievements. I am looking forward to meeting some more of our staff at this year's event. All our staff work hard and it was superb to see that rewarded in a more formal way.

It would be remiss of me not to thank all our hospital volunteers who provide an invaluable service to our patients across the hospital. In particular it has been good to see a greater number of young volunteers joining the service and I hope that they will remain with us for a long time.

I hope you enjoy reading this report and like me, recognise the hard work, dedication and commitment of the staff at City Hospitals who strive to provide us with high quality, safe and innovative services.

JOHN N ANDERSON QA CBE
Chairman

Chief Executive's Statement

It's been another challenging year for City Hospitals, with pressures being evident in almost every department across the whole organisation. However, in general terms, I have been delighted at the way our staff have responded, and in particular in dealing with one of the worst winters we have seen in recent times, together with the threat of a major flu epidemic. Our front line – sometimes working in very difficult and testing conditions – have kept quality and safety at the forefront of what they do, and patients who use City Hospitals continue to enjoy 'excellence in health'. Where we have not always delivered the right quality of care – which thankfully is still very much in small numbers – then we have been prepared to acknowledge this and to try and learn lessons to prevent it happening again.

The context for the year was a daunting one. The Trust achieved a double 'good' in the Healthcare Commission's 2008/09 targets, covering both quality and use of resources.

This was despite our overall performance scores being better than they were in the previous year when we received a higher rating! We had set our annual plan for 2009/10 to deliver a surplus of £2m, with an internal cost improvement target of £8.6m – which itself was a jump of 72% over what we delivered in 2008/09. Despite the pressures, City Hospitals achieved a £1.22m surplus in 2009/10, and although that was below our plan, it was due to a very late (negative) adjustment to our depreciation charge against our assets in year and the Board's decision, again in the last quarter of the year, to spend almost £250k on extra radiology capacity to help alleviate access and reporting problems within the department. Without these two items, financial performance would have been close to our original plan. Margins on our trading activity continue to remain thin, and the cost of over trading with Commissioners comes at a premium – a cost that we and they cannot afford to continue in what will be even more difficult financial times ahead. On a pleasing note we were successful in delivering our savings targets and the Trust's cash/liquidity position was ahead of plan at £17.15m.

Operational performance has again been generally strong across all performance targets, with virtually all national targets being delivered or exceeded. Overall inpatient, daycase and outpatient activity has continued to grow and in 2009/10 we treated 59,565 inpatients, 53,246 day cases and 314,562 outpatients. After successfully delivering the 18 week operational standard in 2008/09, the challenge in 2009/10 was to deliver this in every single specialty across City Hospitals, particularly in Orthopaedics. I am delighted that we achieved this – and in all other specialties – by October 2009 – one of the first large organisations to do so in the North East. Control of Infection has continued to be a key source of focus for all the Trust's staff. Whilst seeing year on year improvements against the MRSA target, we did not achieve the absolute target in 2008/09. However we have rectified that in 2009/10 and achieved exactly the target set for us of 20 cases (almost a 40% improvement against 2008/09).

My personal thanks go to all who have helped towards this excellent result. Our performance on the other key infection target – Clostridium Difficile – was even better this year. Against a target of 210 cases (post 48 hours) we recorded only 93 cases – a 56% improvement in 2009/10 and another excellent performance. The Trust also received another unannounced Hygiene Code inspection visit in October 2009 – this time I was here for it and not away on holiday unlike the 2008 visit! The visit and subsequent report were excellent and no items of concern were reported back to us by the Care Quality Commission – again a fitting testament to our staff's efforts and commitment to this key quality item.

> Our staff coped tremendously and I would like to thank you all for your hard work.

I have already mentioned the challenging winter we had this year and those pressures were felt again most acutely by our Accident and Emergency Department. Whilst they have struggled at times to cope with demand, and as a consequence the 4 hour wait target has not always been met at Sunderland Royal Hospital, I am pleased that the more important (and relevant) Care Quality Commission city-wide 4 hour target was met, and our staff made a particularly herculean effort in March to get us across the line. The whole team was an obvious choice to receive my special award at this year's Reward and Recognition event at the Stadium of Light. It's worth remembering that the team are dealing with over 112,000 attendances (up about 9% over 2008/09), in essentially the same physical building/space that we had when the department was first built in the mid 1970s – over 30 years ago! The targets get more challenging again in 2010/11 so they know a mountain lies ahead but I hope that our new capacity and other changes will help them deliver the sort of quality service they and we so desire. The other significant areas that require more attention in 2010/11 will be stroke care (improving the service and the time patients spend in our dedicated stroke unit) and the 62 day cancer performance, which with the necessary improvements in radiology already in hand, needs to improve by at least 5% to ensure sufficient margin above the national target.

Our workforce continues to be our biggest asset and our second very successful Reward and Recognition event was again the showcase for the talent that we have in City Hospitals.

This year's event attracted over 190 people and it is becoming so popular that even the Stadium of Light may struggle to accommodate us in the future. My congratulations to all those who attended and even if you didn't get a particular prize you are all winners in one way or another. We also launched for the first time a new recognition scheme for staff whose attendance record was exemplary. I know that not everyone was in favour of this, but we felt it was worth trying and for those whose name came out of the draw it was clearly a great success – we will be continuing with this next year but we will review its scope and rewards in advance to ensure that they remain appropriate. .

The Trust also had to demonstrate compliance with the European Working Time Directive, which came into force in August 2009. I am pleased to report that we have compliant rotas and that this is now kept under constant review to ensure that no excessive hours are worked by our junior doctors in particular.

As I write this report three of our staff, Scott Elwell, Karen Maw and Chris Wood, will be in final preparation for their charity climb of Mount Kilimanjaro. We wish them well for a safe and speedy ascent and descent, together with lots of money for the charities involved.

Our volunteers continue to go from strength to strength and on the regular occasions when I meet them they continue to amaze me with their dedication and commitment.

They are never short of ideas either about how the hospital could be better! Denise Walter's retirement in 2009/10 did leave a little bit of a void, but I'm pleased to report that Audrey Barrass will be picking up the mantle and together with Shirley Gillum, they will ensure all our volunteers have the help they need from the organisation. Thank you to all our volunteers, and whilst the money generated by the WRVS shops is very welcome, it is the efforts on the ground with patients that really make the difference.

As usual our hospitals have continued to change and I believe that despite many competing claims for resources we must maintain the quality of our physical assets. Early in the year we brought on stream our combined heat and power system – saving a substantial amount of carbon output and energy costs at the same time, and our two new robots in Pharmacy are now well bedded in and demonstrating improvements in safety and accuracy with our drug handling. The Trust also received £640k from the Department of Health to improve patients privacy and dignity, and as a result of this investment (and other changes) we were able to comply with the Department of Health's guideline of virtually eliminating all mixed sex accommodation by 31 March 2010. There is still further work to do in 2010/11 to improve this further, which I shall report upon in next year's annual report. We have continued to invest in backlog maintenance where necessary, and as a result of the Fire Action report we received during the year, more will need to be done in coming years on this subject. However, the bulk of our expenditure and focus this year has been on our next new development, which is due to open in the late summer of 2010. This will allow us to replace a good deal of the older ward accommodation with new purpose built wards and develop a brand new, all single room, Intensive Care Unit. There will be some new ward capacity which will give us the buffer we have not enjoyed for some years to manage potential future demands more sensibly. As a result of this, and another new extension on Chester Road (to be known as Chester Lodge), we have finally started the last phase of demolition of the Kayll Road block, which when it is complete in 2011 will finally open up more much needed car parking capacity. I am pleased there is an end now in sight with this, but would reiterate again that this will help but not resolve all our parking pressures. Members of the public will also notice the smoking shelters that have been restored, one outside outpatients and the other between the main entrance and the Accident and Emergency Department. We have done this very reluctantly and are keeping their use and effectiveness under regular review.

The year has not been without some disappointments, particularly regarding some aspects of our care.

Episodes of wrong site surgery, one or two well publicised negligence cases and the two Rule 43 letters from the Coroner are a constant reminder that we are not perfect in everything we do. Themes around communications and correspondence feature across many of these issues and we shall be endeavouring to improve these going forward – and in addition I hope to also see a major improvement in our Radiology services, both access and reporting. I still take the view that there is much to be learnt from these issues, painful though they are, and that we need to ensure that we have the right mechanisms in place throughout City Hospitals to feed back to all directorates. Our participation in the national Leading Improvement in Patient Safety programme for 2010/11 will also benefit patient care and safety further.

It was a relatively stable year for the top team in 2009/10 with two notable exceptions. Firstly, George Hood retired as Director of Estates after a long and distinguished career – almost all our major schemes over the last 30 years or so have George's stamp on them, and he should be proud of what he brought to City Hospitals Sunderland. We all wish him – and Susan – a long and happy retirement. Secondly, Mark Smith was formally appointed as a Director after a period of secondment from the North East SHA. We have all missed Carol Scholes (who we wish a speedy recovery) and I am indebted to Judith Hunter, Hilary Lloyd, Andrea Stubbs and Denise Brown for helping me cover the gap. As usual the Directors have supported me throughout 2009/10, and I know everyone expects them to work hard but believe me they really do, and the organisation should be proud of the leadership they bring. To our Non Executive Directors, led by John Anderson, Chairman, I am also extremely grateful. They give much more of their time than many people realise and quite properly hold the Executives to account for performance on everything from governance, hygiene, cleanliness, as well as the money. They all contribute in their own way and that contribution will be needed even more in the choppy waters that lie ahead.

My thanks also to the Governors – staff, public and patient – who voluntarily give their own time in an effort to help improve our service to patients. I hope they continue to enjoy the experience and that we will see many, if not all, stand again in the forthcoming Governor elections.

You can never rest on your laurels in this job – there is so much to do and improve upon and the Board of Directors and myself are determined to keep City Hospitals as a high performing organisation, not forgetting that high quality and safety must be the highest priority for everyone who works in the organisation. In the very tough times that lie ahead I need everyone to remember that.

KEN BREMNER

Chief Executive

> “High quality and safety must be the highest priority for everyone who works in the organisation.”


Acuity

Operating and Financial Review

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 (NHSFT) 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)
- Ryhope General Hospital (on a limited basis)
- Monkwearmouth Hospital (on a limited basis)

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 945* acute beds, an annual income of around £285.64m and fixed assets of £190.89m. It employs around 5000 people.

* our winter contingency ward of 20 beds had closed as at 31 March 2010

Staff Group	Percentage	Headcount
Professional and Technical	3.52	176
Clinical Services	19.06	952
Administrative and Clerical	21.04	1.051
Allied Health Professionals	6.55	327
Estates and Ancillary	8.71	435
Healthcare Scientists	1.64	82
Medical and Dental	7.99	399
Nursing and Midwifery	31.35	1,566
Students	0.14	7
	100%	**4,995**

As at 31 March 2010

Membership of the Trust's Board of Directors and Executive Team is given in the Year at a Glance section at the front of this report.

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 Surgery

- General Surgery and Urology
- Head & Neck Surgery (including Ear, Nose & Throat, Oral & Maxillofacial Surgery & Orthodontics)
- Ophthalmology
- Trauma & Orthopaedics
- Theatres (including ICCU, Anaesthetics, Critical Care and the Day Case Unit)

Division of Medicine

- Emergency Medicine (including Accident & Emergency, Cardiac Centre, and Acute Medical Unit)
- General Internal Medicine (including Respiratory Medicine, Nephrology, Gastroenterology, Clinical Haematology, Clinical Oncology, General Medicine)
- Rehabilitation and Elderly Medicine (including Care of the Elderly, Neurology, Neuro-Rehabilitation and Rheumatology)

Division of Family Care

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

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 Estates and Facilities

- Catering
- Domestics
- Estates
- Laundry & Linen
- Outpatients
- Portering & Security
- Theatre Sterile Supplies Unit – Sterile Services
- Transport

Department of Trust Headquarters

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

Staff Consultation and Involvement

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

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

- team debriefs following Executive Board meetings to cascade key strategic messages across the Trust and to encourage feedback;
- "roadshows" delivered by Executive Board members to staff out in the workplace to communicate key issues;
- staff focus groups to inform the Trust's approach to various initiatives such as the Productive ward, recruitment improvement project and stress risk assessments;
- the weekly 'Grapevine' bulletin is published on CHSnet, the Trust's intranet;
- the publication of Good4You, an employee health and wellbeing newsletter; and
- well-established intranet and internet site giving information on key strategic issues and directorate/departmental news.

We also have a well-established and effective Joint Consultative Group (JCG) with excellent management/staff side relationships. During the year the JCG has been involved in regular discussions and agreement surrounding key HR policies.

Monitoring and Managing Performance

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

- monthly reporting of activity, waiting list and key performance indicators to the Executive team and Board of Directors;
- monthly reporting of financial performance to the Executive Board team 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

- detailed monthly reports for Divisional Directors, Directorate Managers and Clinical Directors;
- monthly meetings with Directorate Managers and representatives from Finance, Strategy and Service Development and Performance to identify trends and areas of concern in time to plan ahead and agree action plans;
- 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; and
- involvement in performance forums external to the Trust to consider shared issues.

The Chief Executive also holds a number of regular forums with Clinical Directors, Senior Managers, Consultants, key nursing staff and allied health professionals to ensure that senior staff are kept up to date with progress against targets and are able to communicate within their own directorates.

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

Details of Financial Performance may be found on page 66 of the Operating and Financial Review.

KEY AIMS AND OBJECTIVES

The ethos of the Trust is based on our mission statement:

> 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 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:

- driven by clinical quality;
- creating the ideal patient experience;
- listening to our patients, carers and families and learning from their experiences;
- listening to our staff and encouraging them to improve services;
- financial sustainability to invest in the future;
- patient centred, business focused; and
- pride in who we are and what we do.

The Board has continued to drive the Trust's vision through a number of key delivery areas:

- leadership at all levels;
- service improvement;
- performance management framework;
- financial skills and awareness;
- clinical quality strategy;
- market intelligence and customer feedback; and
- information and technology

The Trust is also committed to providing a high quality environment in which staff can work and patients can receive treatment. This has led to the completion of the following schemes during 2009/10:

- provision of a new angiography interventional room in the radiology department;
- refurbishment and equipping of rooms 6, 7 and 9 in the radiology department;
- the replacement of our CT scanner with a new and greater definition scanner;
- refurbishment of the pathology laboratories;
- the relocation from Sunderland Royal Hospital to the Children's Centre, Durham Road of the citywide Rape, Examination, Advice, Counselling and Help (REACH) centre;
- the development of the new diabetic, endocrine and metabolic medicine centre; and
- the completion of an energy conservation scheme including replacement of the main boiler and a combined heat and power plant.

Work has also commenced on the following:

- the development of a new ward block of 138 beds of which 18 beds will be a new ICCU fit for the 21st century. The new block is anticipated to be operational from September 2010;
- the enhancement of our roads, footpaths and car parking; and
- the preparations required to demolish the Kayll Road block.

Future Developments

There are a number of key priorities for the Trust to deliver in 2010/11. These are:

- financial viability and sustainability;
- delivery of 10% cost improvement plans across all divisions of the organisation;
- ensuring patient safety and better quality of care across the organisation;
- ensuring that control of infection and hospital cleanliness remains a top priority;
- developing a greater customer and market focus whilst improving patient experience;
- ensuring the delivery of national and local targets; and
- embedding service line reporting and service line management across the organisation.

Future Performance

The Trust's future performance is based on a number of factors: financial viability and sustainability, the appropriate training and skill levels in our staff, the capacity to undertake new levels of activity, our ability to offer good quality performance and our skill in competing with other health care providers.

There are no new priorities in the NHS Operating Framework for 2010/11. The five existing priorities being:

- improving cleanliness and reducing healthcare-associated infections;
- improving access through the achievement of the 18-week referral to treatment target and better access to GP and Primary Care Services;
- keeping people well, improving overall health and reducing health inequalities;
- ensuring we improve the patient experience, staff satisfaction and engagement; and
- ensuring robust plans are in place for pandemic influenza and other major incidents.

In addition, the framework identifies four major challenges for the NHS clinical and managerial community to deliver in the coming year:

- continue to deliver on national priorities so that progress is sustained;
- invest resources wisely so as to be able to deliver substantial efficiency savings from 2011 onwards;
- help put in place enablers to deliver the North East Strategic Health Authority's clinically led vision, "Our vision, our future"; and
- develop new ways of working that lead to large scale transformational change.

Going into 2010/11 there will be significant financial pressures associated with the national economic climate. The impact of increasing pressure on the public sector has resulted in an expectation that the NHS will need to deliver greater levels of cash releasing savings over the next three years. As a consequence 2010/11 will be a critical year in preparing for the lean years ahead.

The health care market is becoming increasingly competitive and less collaborative with national policy levels around patient choice and quality such as Commissioning for Quality and Innovation (CQUIN) driving performance and income. Choice of provider for appointments for consultant-led services is now a legal right under the NHS Constitution, as well as the right to have access to information on which to base this choice.

The future financial climate and the requirement to make efficiency savings will mean that services need to be cost effective whilst at the same time delivering a high quality experience and outcome.

Against this backdrop the Trust has identified its top five strategic priorities:

- **Quality** – improving quality so that we continuously improve our performance in terms of:
  - improving patient safety;
  - improving the patient experience;
  - improving clinical effectiveness; and
  - hitting performance targets.
- **Service Line Reporting/Service Line Management** – the SLR/SLM process is an essential part of the Trust being able to develop and deliver devolved leadership.
- **Productivity and Efficiency** – we need to continuously improve to enable us to have the funds to invest in order to improve the quality of patient care and our environment. It will be vital that we continue to develop and roll out our continuous equality improvement methodology, LEAN and Six Sigma.

For LEAN and Six Sigma to work effectively we must change the culture of the organisation to move towards:

- zero waste
- zero defects
- standard work to deliver improved quality and competitiveness

- **Service Redesign** – patients to be at the centre of care, supported by clinical engagement.
- **Investments/Infrastructure** – investments and structural changes will be required to create the capability for efficient delivery of new and improved services in a better clinical and patient environment.

As part of World Class Commissioning, Primary Care Trusts (PCTs) have refreshed their five year strategic plans which will include a focus on shifting care out of hospital and into the community at a reduced cost. A key area of concern is that PCTs are introducing significant primary care based demand management initiatives and it is not yet clear whether this will have an impact on the Trust.

PCTs will be unlikely or unable to fund growth and as a consequence the Trust will need to develop new services and new markets. The Trust has traditionally provided both Ophthalmic and ENT services for Durham patients with outpatient activity centred in the University Hospital of North Durham. County Durham and Darlington Foundation Trust (CDDFT) gave City Hospitals notice to quit with effect from 1 April 2010 and declared its intention to compete with us on a head to head basis. The Trust has chosen to compete and to continue to deliver these services from an alternative outpatient facility using a private provider for diagnostics. In addition the Trust will be providing services in both Shotley Bridge and Stanley in order to consolidate its market share.

Work will also continue during 2010/11 in partnership with Church View Medical Centre to look at different models of delivering integrated care. The development is one of sixteen national integrated care pilots whose aim is to integrate and co-ordinate the care for elderly patients to help prevent avoidable admission and re-admissions.

The Trust recognises the many challenges that lie ahead and it will be important to look at innovative ways of delivering services and improving patient care and experience in the context of a difficult financial climate.

> “Services need to be cost effective whilst at the same time delivering a high quality experience and outcome.”

Year End Position

City Hospitals has reported a surplus position of £1.22m for the financial year 2009/10.
The financial position was behind the planned surplus of £2.0m submitted to Monitor at the start of the financial year. The Trust delivered its cost improvement target, with £9.27m being delivered in year. The delivery of cost improvement targets was closely monitored in year by the Productivity, Efficiency and Savings Committee (PESC).

For 2009/10, 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 2009/10 contract baselines predominantly based on the 2008/09 actual activity delivered with funding specifically relating to the maintenance of the 18 week milestones. In activity terms, the overall elective contract over-performed slightly against this baseline by 0.2% whilst the non-elective contract over-performed by 3.7% with income and expenditure consequences, particularly in the medical specialties.

The Trust received a 'good' rating in the Annual Health Check for 2008/09 for both the quality of its services and for the use of resources (finance).

Regulatory Ratings Review

Monitor, our independent regulator assesses Foundation Trusts on the basis of risk ratings. The three ratings are detailed in the tables below. The ratings are:

- Financial Risk Rating – a measure of the Foundation Trust's financial performance. This measure is a composite measure and considers the overall income and expenditure position, the underlying trading position, and rate of return and liquidity. A poor performance equates to a score of '1' and the best performance equates to a score of '5'.
- Governance Risk Rating – a measure of the Foundation Trust's performance against a range of performance targets. Green equates to achievement of all relevant targets; amber relates to non achievement of a target with a weighted score of '1' or more and red relates to non achievement of more than one target with a score of '4' or more.
- Mandatory Services – a measure of the Foundation Trusts delivery of all services as identified within the Trusts Terms of Authorisation.

	Annual Plan 2008/09	Qtr 1 2008/09	Qtr 2 2008/09	Qtr 3 2008/09	Qtr 4 2008/09
Financial Risk Rating	3	2	3	3	3
Governance Risk Rating	Amber	Amber	Amber	Green	Green
Mandatory Services	Green	Green	Green	Green	Green

	Annual Plan 2009/10	Qtr 1 2009/10	Qtr 2 2009/10	Qtr 3 2009/10	Qtr 4 2009/10
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Amber	Amber	Green	Amber	Amber
Mandatory Services	Green	Green	Green	Green	Green

Summary of Performance

The Trust submitted a plan at the start of the 2009/10 year that identified a risk around the achievement of the MRSA target of a maximum of 20 cases in year. As a result the governance risk was highlighted as an 'amber' risk. At the end of quarter 1, 5 cases of MRSA were seen compared to a target of a maximum of 4. Therefore the governance rating was amber on that quarter. This position subsequently improved with the result that there were no further breaches of the MRSA target in the remainder of the year. Quarter 3 and 4 saw breaches in the achievement of the target associated with 98% of patients having to wait less than 4 hours for treatment within A&E. Action plans have been submitted to Monitor and joint work has been undertaken with the health community to address this issue. The financial risk rating remained as a '3' all year, and the mandatory services rating remained as a green. Therefore, overall the Trust achieved the risk ratings in line with the original plan submitted.

In 2008/09, the Trust achieved a financial risk rating of '3' and green on both the governance risk rating and the mandatory risk ratings. The governance risk rating was an improvement against the original plan of 'amber' associated with the MRSA target. Compared to the planned targets, the actual position for the financial and governance risk ratings, and the mandatory services were either achieved or better than planned.

The Trust was also named as one of the best performing Trusts in the UK in the Caspe Healthcare Knowledge Systems (CHKS) Top Hospitals Awards. CHKS are an independent provider of healthcare intelligence and quality improvement services.

Medical Director, Les Boobis and Business Intelligence Manager, Stephen Jobling receiving one of CHKS' Top Hospitals Awards.

RISK MANAGEMENT

Financial Risks

Key financial risks during 2009/10 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 complete change to the overall contract income baselines with a range of inherent new risks;
- delivering against the CQUIN targets as agreed with the PCT;
- balancing a combination of over and under commissioning in different clinical specialties and also variations in case-mix;
- the delivery of additional activity within existing staffing and physical capacity resources;
- continuing to deliver on elective activity whilst non elective workload (particularly over the winter) increased above plan;
- addressing the impact of the International Financial Reporting Standards (IFRS) on the capital assets of the Trust; and
- the impact of pandemic flu preparations.

Non-financial Risks

Non-financial risks for the year included:

- achieving and maintaining the 18-week target for 95% of admitted patients in year across all specialties;
- achieving the MRSA target of 20 cases for the full year;
- achieving the stroke target of the number of patients who spent more than 90% of their time on a stroke unit;
- achievement of the new 62 day cancer target;
- preparing for the implications of registration with the Care Quality Commission; and
- maintaining the standards required by the Healthcare Commission in relation to the Hygiene Code.

Directors' Approach to Risk Management

Directors' Approach to Risk Management includes:

- a Cost Improvement Plan to reduce the Trust's operating costs during 2009/10 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;
- managing the levels of actual activity and the costs associated in specialties with capacity constraints.

The Board of Directors is responsible for ensuring that the Trust's system of internal control and risk management is sound and for reviewing the effectiveness of those systems.

The Trust has processes for identifying, evaluating and managing the significant risks faced by the organisation. These processes cover all material controls, including financial, clinical, operational and compliance controls and risk management systems. These processes have been in place for the whole of 2009/10.

During 2009/10 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,
- 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. The Trust has achieved level 3 compliance for Maternity Services, which ensures a 30% discount on the maternity scheme contributions for a period of 3 years. The Trust is currently building on this success by preparing for assessment at level 2 for the general acute standards during 2010/11.

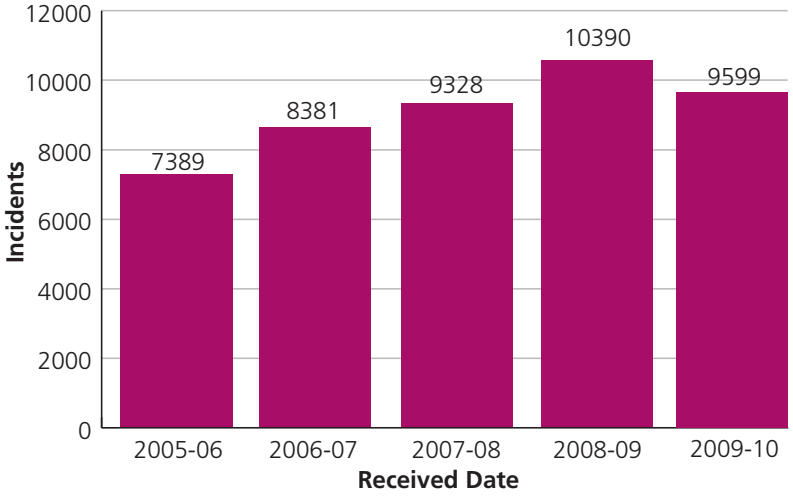
The Board of Directors has approved an assurance framework that meets national guidance which is managed by the Corporate Governance Committee. The framework is subject to annual review and approval by the Board of Directors. The framework is based on the Trust's strategic objectives and contains an 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.

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.

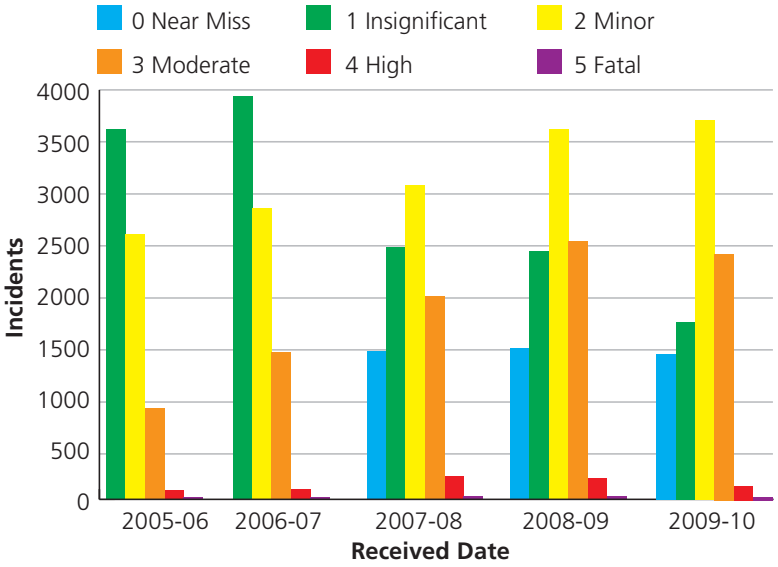
Incident Reporting

The Trust's Risk Management Strategy governs the reporting, analysis and investigation of all strategic, managerial, operational and financial risks within the organisation. It exemplifies the Trust's continued commitment to delivering improved patient, staff and public safety through performance-driven risk management, underpinned by an open, learning culture.

During 2009/10 a total of 9599 incidents involving City Hospitals Sunderland were logged on the Trust incident database a decrease of 7.6% on the previous year. This reflects the Trust's introduction of a comprehensive electronic incident reporting system which has enabled the improved identification of incidents which whilst reported by City Hospitals staff originated from other organisations e.g. North East Ambulance Service, nursing homes and PCT services.



All incidents are given an impact grading and it is anticipated that as the Trust reporting system and safety culture reach maturity the level of reporting will continue to increase but there will be a corresponding decrease in the level of severity of impact. There has been a significant number of "near misses" reported over the last three years and this is recognised to be indicative of a strong safety culture within an organisation.



Service Improvements

During 2009/010 a wide range of improvements have been implemented as a result of lessons learned via the incident reporting procedure.

These include –

- A mechanism has been developed and implemented Trust wide, which ensures that all patients requiring specialist blood transfusions have a visual alert attached to their records. This provides an immediate prompt to clinical staff and is recognised as good practice in reducing the potential for transfusion errors.
- Establishment of a Deteriorating Patient Focus Group which has been instrumental in the roll out of a trust wide Early Warning Score (EWS) system central to which is a single chart for the recording of all key observations. The introduction of this system has included a programme of awareness raising to highlight the importance of combining the use of EWS triggers with clinical judgement to take appropriate action. This has been supported by the development of a rolling programme to ensure all relevant clinical staff complete certified critical skills training.
- Establishment of a process which confirms that the testing of fire alarm system integrity is incorporated in the commissioning processes for all new building work to make sure that at all times the Trust has comprehensive coverage of all premises.
- Data Quality processes have been reviewed and additional checking mechanisms have been introduced to enhance the integrity of data being entered into the hospital information system, thereby supporting assurance that all activity is correctly coded.
- Introduction of a system which facilitates the electronic flagging of patients who are a potential security risk to the organisation, e.g. drug addicts who have a history of theft or attempting to sell or purchase drugs within a hospital setting. Flagging of such patients at the point of admission enables staff to identify that appropriate levels of supervision and monitoring can be put in place in a timely manner to guarantee the safety of all concerned.
- Policy for responding and acting upon emergency bleep test calls has been reviewed and a routine system of testing for 'black spots' initiated in order to identify any potential problem areas and allow appropriate action to be taken at the earliest possible opportunity.
- Improved mechanisms for the prescribing of chemotherapy drugs have been introduced; these include the addition of a prompt on the Hospital Information System bulletin board, which alerts staff to the need for involvement of the Chemotherapy Day Unit team at the point of admission. This alert means that patients have timely and appropriate access to specialist care. This has been supported by targeted training to increase awareness amongst nursing staff of the needs of this specific group of patients.
- Bowel screening guidelines have been reviewed and amended where indicated, in conjunction with regional and national guidance, to make certain that best practice is followed and that the risk of recognised complications occurring is reduced as far as possible.
- Mechanism developed by which any change in cleaning methodology must be discussed fully with all stakeholders before implementation. A revised specification for cleaning, which includes the method and frequency of cleaning, has been implemented Trust wide along with a vigorous monitoring programme.

Information Governance

Information Governance sits alongside other NHS Governance initiatives such as Clinical Governance and Research Governance. It relates to the way the NHS handles information about patients/clients and employees, and in particular personal and sensitive information. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

The Trust can confirm that it has systems and processes in place to safeguard confidential and personal information.

The Trust can also confirm that there were no serious untoward incidents involving data loss or confidentiality breaches during 2009/10.

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.

Research and Development

The Trust has enjoyed a year on year increase in portfolio research since the change from the old Culyer structure to the new Cooksey reforms. In 2006 Sir David Cooksey proposed wide reaching reforms in the way that research is supported and delivered in the NHS. Implicit in this is the need for the NHS to deliver research in line with national priorities as defined by the National Institute for Health Research. The consequences of these changes for the Trust has seen a marked increase in Comprehensive Local Research Network (CLRN) funding with continued expansion in research accruals. CLRN income for 2009/10, including PAs for consultant time, totalled £513,500. Initial indications for 2010/11 funding are that this has been uplifted to around £552,721 although this is yet to be confirmed.

Both R&D funding and R&D activity (staff) are managed through the CLRN in line with national strategy and the overall amount of funding continues to be dependent upon the number of patients being recruited to trial activity.

Commercial studies are also considered a priority for both CRLN and the Department of Health under Best Research for Best Health. By way of support CRLN has appointed an Industry Manager to co-ordinate uptake within various Trusts, including City Hospitals to ensure a speedier completion of the Central Sign off Procedure(CSP). There are often significant funds attached to such studies, over and above the income received from the CLRN.

Academic studies, adopted to the portfolio can increase income to the Trust which in some cases is an arbitrary and nominal figure, whilst in others can be significant. An example of successful delivery is Obstetrics and Gynaecology "Building Blocks" which funded a 0.5wte research midwife and clerical support whilst at the same time also accessing CLRN funds. This initiative is to be showcased within the national CLRN newsletter as evidence of effective partnership working between Sunderland TPCT and the Trust.

During October 2009 Professor Chris Gray our academic lead and Director of R&D left the Trust to take up the post of Postgraduate Dean at Newcastle University. The Trust is indebted to Professor Gray for the work he undertook to ensure that the Trust remained at the forefront of developments.

His successor as Director of Research is Mr Kim Hinshaw, Consultant Obstetrician and Gynaecologist.

The R&D department has also been strengthened by the appointment of Teniola Oshodi, research statistician.

As a host organisation the Trust is also responsible for the Research Governance of both comprehensive research studies and our own account work, including student research, which incorporates:

- feasibility of delivering protocols;
- assessing the qualifications, experience and training of research teams; and
- ensuring that support departments such as finance, medical physics, pharmacy, laboratories and public relation leads, have reviewed the protocols and inherent risks prior to study sign off.

All researchers at all levels must demonstrate evidence of training in research processes and regulatory standards.

The need to incorporate research as part of the Trust's core business, as identified in the NHS Constitution, is essential.

The main area for development during 2010/11 will be working with the CLRN to deliver their key objective of "increasing the number of patients recruited into NIHR portfolio studies, working towards the NHS Operating Framework goal to double the number of patients recruited to studies over the next five years".

The Trust must also balance the high volume of resource required to deliver the CLRN strategy against the need to make sure that appropriate governance procedures are in place. These procedures will be measured by the Medicines and Healthcare products Regulatory Agency (MHRA) who are due to inspect the Trust either later in 2010 or early 2011.

The continued development of R&D will be a key milestone going forward into 2010/11.

“Medical Director, Les Boobis is one of a number of staff who regularly cycle to and from work.”

Role of the Trust as a Local Employer

The success of the Trust is dependent upon the staff we employ and their dedication and commitment to ensure that we deliver high quality care to our patients.

The Trust is a significant employer within the local community employing just under five thousand staff. We have updated our Workforce Plan to reflect the changes that have taken place within the Trust but also to identify key workforce development needs to meet our strategic plans and to identify areas of potential workforce pressure.

During 2009/10 we have implemented a range of initiatives to provide work experience to a wider range of people, with a view to moving them towards employment.

- Participation in an initiative funded by the Strategic Health Authority Workforce Development Innovation Project which involved various public sector and voluntary agencies within the City. Detailed work has been undertaken with the City Council to support the city wide strategy of reducing worklessness and ensuring job seekers are equipped with skills for future jobs.
- Over seventy Future Jobs Fund placements have been offered within the Trust to enable long term unemployed people to gain skills in a real life job environment in the hospital. It is hoped that some of the individuals currently in placements will move into long term employment within the Trust as opportunities arise.
- Our work with the Future Jobs Fund has been shortlisted for the "Creating Futures" category of the North East "Celebrating Learning and Skills Success" (CLASS) awards, as well as being one of the two employer representatives asked to be a panellist alongside the Rt.Hon. Jim Knight MP, at a regional Department for Work and Pensions, "Backing Young Britain" employers event.

The Trust is also being used by the Strategic Health Authority and Jobcentre Plus as a case study of how to tackle worklessness whilst building a pool of suitable recruits for vacancies when they arise.

As part of our commitment to make the Trust a better place to work, and thereby improve patient care, several health and wellbeing initiatives were undertaken:

- the Trust has been selected as one of four NHS Trusts in the North East participating in Cycling England North East Demonstration Project. The aim of the project is to increase the number of employee journeys to work by bicycle. The Trust will receive support in both funding and specialist advice to help promote cycle use, increase the facilities available for cyclists, and measure the incidence of cycle use across the Trust.
- in partnership with NHS Fleet Solutions a new salary sacrifice scheme was launched to allow staff access to cars with CO^2 emissions of 155k/mg or less.
- scheme organised by Go North East, "Buzzfare", provides staff with an annual bus ticket offering unlimited travel on the company's buses at considerable savings.
- a second Employee Benefits Day was held which was attended by almost 1000 staff. The event promoted the many benefits that are available to staff and also gave information and advice on matters such as health and fitness, diet, smoking cessation, NHS pension scheme, trade union membership, and discount rail travel. A range of external companies and local colleges exhibited at the event, including NHS Fleet Solutions, Sunderland College, Imagine Co-Operative Childcare, Go North East, FirstAssist and NHS Discounts.
- the launch in June 2009 of the Trust's Attendance Award Scheme to acknowledge those staff who had achieved a 100% attendance record. Over 1140 staff who had had no sickness absence were entered into a year end draw with three prize winners receiving travel vouchers.
- a second Reward and Recognition event was held to celebrate the many and varied contributions that our staff make to patient care. The evening also celebrated those staff who had achieved thirty and forty years service in the NHS, which in most cases had been in Sunderland.

The success of the Trust is dependent on our ability to communicate and effectively engage with our staff in all that we do.

The Trust participates in the NHS Annual Staff Survey which seeks the views of staff on a wide range of issues. The results of the 2009 staff survey were published in March 2010 and overall, the report shows similar results to those from 2008 with 45% of staff responding against a national response rate of 55%.

The key findings from the survey are outlined below:

2008/09 Response Rate		2009/10 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
45%	55%	45%	55%	no change

Top 4 ranking Scores

Perception of effective action from employer towards violence and harassment

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 takes highly effective action. The Trust's score of 3.73 was in the highest (best) 20 % when compared with Trusts of a similar type.

2008/09 Response Rate		2009/10 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
3.65	3.54	3.73	3.55	0.08 %

Percentage of staff reporting errors, near misses or incidents witnessed in the last month

The Trust's score of 97% was in the highest (best) 20 % when compared with Trusts of a similar type.

2008/09 Response Rate		2009/10 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
95%	95%	97%	95%	2%

Percentage of staff working in a well structured team environment

Forty three percent of staff at the Trust said they work in a team of 15 or fewer people which has clear objectives, and in which team members work closely together to achieve their objectives, and meet regularly to discuss the team's effectiveness and how it could be improved. The Trust's score of 43 % was in the highest (best) 20 % when compared to Trusts of a similar type.

2008/09 Response Rate		2009/10 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
41%	37%	43%	38%	2%

Percentage of staff suffering work-related stress in last 12 months

The Trust's score of 24 % was in the lowest (best) 20 % when compared with Trusts of a similar type.

2008/09 Response Rate		2009/10 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
28%	27%	24%	28%	4%

Bottom 4 ranking Scores

Percentage of staff feeling valued by their work colleagues

Seventy three percent of staff in the Trust agreed with at least 3 of the following statements:

- that their colleagues treat them with respect;
- that their colleagues seek their opinions;
- that they are trusted to do their job; and
- that they feel part of a team.

The Trust's score of 73% was in the lowest (worst) 20% when compared with Trusts of a similar type.

2008/09 Response Rate		2009/10 Response Rate		Trust Improvement
Trust	National Average	Trust	National Average	
74%	75%	73%	77%	1%

Staff motivation at work

Staff were asked questions about the extent to which they look forward to going to work, and are enthusiastic and absorbed in their jobs. Possible scores range from 1 to 5, with 1 representing staff who feel poorly motivated and 5 representing highly motivated staff. The Trust's score of 3.77 was in the lowest (worst) 20 % when compared with Trusts of a similar type.

2008/09		2009/10		Trust Deterioration
Trust	National Average	Trust	National Average	
This finding was not calculated in 2008 survey		3.77%	3.84%	n/a

Percentage of staff suffering work-related injury in the last 12 months

Nineteen percent of staff at the Trust said that, in the last year, they had been injured or felt unwell as a result of at least one of the following:

- moving and handling injury;
- needlestick and sharps injuries;
- slip, trips or falls; or
- exposure to dangerous substances.

The Trust's score of 19 % was in the highest (worst) 20 % when compared with Trusts of a similar type.

2008/09		2009/10		Trust Deterioration
Trust	National Average	Trust	National Average	
16%	17%	19%	17%	3%

Percentage of staff having well structured appraisals in last 12 months

Twenty five percent of staff at the Trust said that they had received an appraisal or performance development review in the last 12 months, in which they had agreed clear objectives for their work, which they had found useful in helping them improve how they do their job, and which had left them feeling that their work is valued by their employer. The Trust's score of 25% was in the lowest (worst) 20% when compared with Trusts of a similar type.

2008/09		2009/10		Trust Deterioration
Trust	National Average	Trust	National Average	
28%	26%	25%	30%	3%

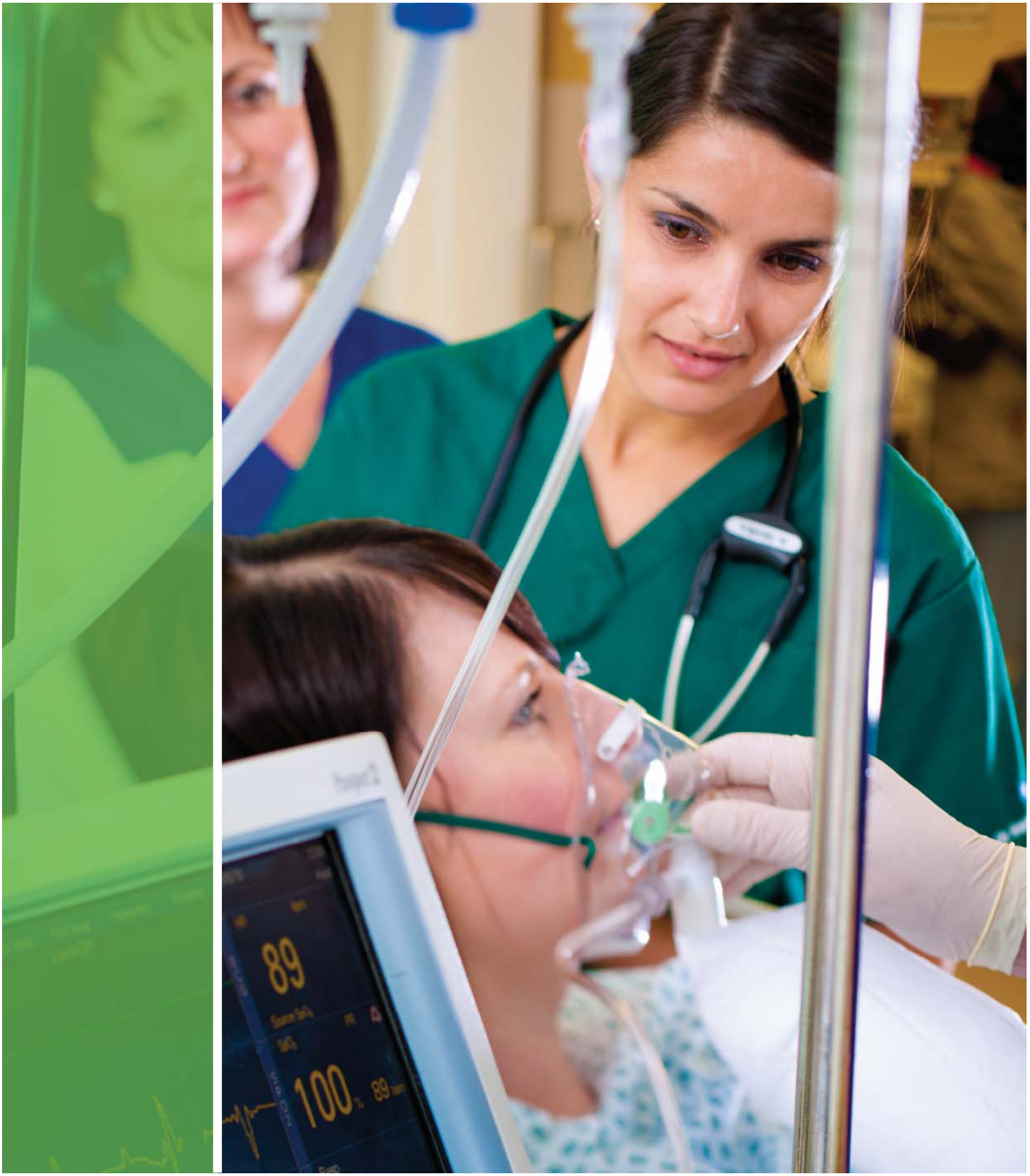
There is still significant room for improvement, particularly in terms of staff motivation and work-related injuries and detailed reports will inform a series of actions not only at Trust level but also at Divisional and Directorate level to deliver improved performance next year.

Following discussion within the organisation, three key staff concerns have been identified to address during 2010/11.

- Communications and staff engagement;
- The extent to which staff feel the care of patients is the Trust's top priority; and
- The extent to which staff feel the Trust values their work.

The following actions will be a key focus of work:

- Rolling out a formal Team Brief system across all areas to encourage 'bottom up' communication;
- Publishing regular Chief Executive Updates to communicate key messages and positive patient stories to staff;
- Publishing regular Good4U bulletins to promote staff benefits;
- Ensuring that all staff have yearly appraisals, objectives and personal development plans;
- Making certain that all staff are up to date with core mandatory training, including IT training to support the roll out of e-learning.
- The completion (as a minimum) by all managers of the ILM Level 3 programme;
- The development and implementation of an effective strong Leadership Development Strategy;
- Ensuring that weak/badly managed teams are identified and performance management processes are implemented;
- Involving staff in service changes through the use of Lean/Six Sigma;
- Developing, implementing and publishing a Health and Wellbeing Strategy; and
- Ensuring that all departments have completed stress risk assessments, and developed action plans to address the risk factors.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Quality Report

Part 1:
Chief Executive's Statement

> We have no option but to meet the financial challenges, but in doing so I will make sure that we do not lose momentum in improving standards of care.

City Hospitals Sunderland NHS Foundation Trust is delighted to present its second Quality Report covering the year 2009-10.

The report reflects our performance and progress on quality, safety and the patient experience during 2009-10 as well as looking forward to key areas on which to focus particular attention during 2010-11. Our ambition is to maintain City Hospitals position as one of the top performing trusts in the country,

In my introduction to the inaugural Quality Report last year I said that it had been a pivotal year for quality. The focus and direction of the Darzi reforms combined with the aftermath of the Mid-Staffordshire review provided many new opportunities and challenges for the NHS. In addition the emerging financial situation provides an ever more demanding strategic and operational context.

A year on, the Organisation is acutely aware that the quest for quality improvement is paramount and must not be compromised no matter what the economic climate. We have no option but to meet the financial challenges, but in doing so I will make sure that we do not lose momentum in improving standards of care. We will all work together to protect and promote quality while looking critically and carefully at ways to increase productivity, eliminate waste and release savings wherever we can.

The promise I will make is that City Hospitals will focus relentlessly on clinical quality and look to enhance the patient experience in these testing times. We have already set out plans on how we intend to do this which I believe will have the full support of our staff.

Our greatest asset is undoubtedly our clinical and non-clinical staff, and the supporting services and departments that create the right environment to deliver high quality healthcare. I'm extremely grateful for their continued dedication and commitment to raising standards and improving patient care.

I hope that our second Quality Report provides a level of assurance that quality improvement is at the heart of what we do. Our overall performance suggests that we are doing well but there are obviously areas where we can do better. We include in the report our clinical quality and safety priorities which we will measure, monitor and report on next year.

KEN BREMNER

Chief Executive Date: 02 June 2010

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

Priorities for improvement

In our first quality report 2008-09 we confirmed our top priorities in each of the dimensions of quality: patient safety, clinical effectiveness and patient experience.

Priority 1:
To further reduce the rates of avoidable hospital acquired infection

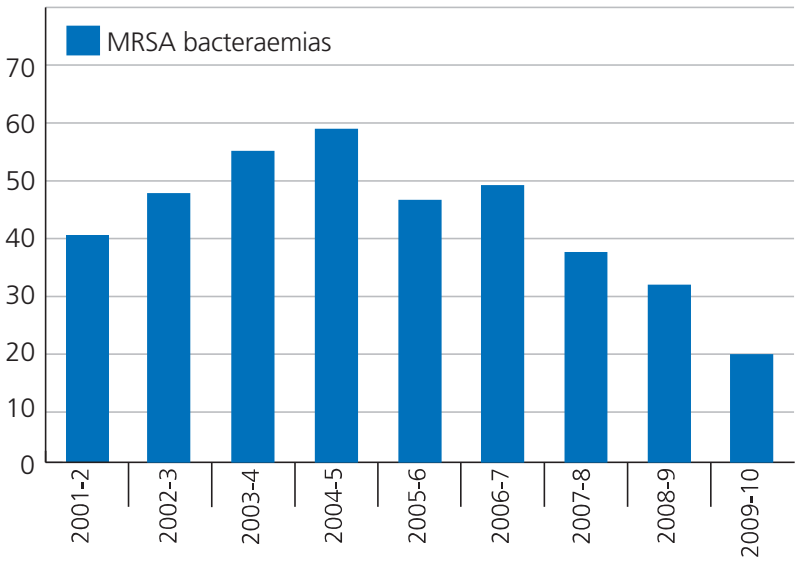
Hospital acquired infections (HAI) are infections that are neither present (nor incubating) when a patient enters hospital. About 9% of inpatients have a hospital-acquired infection, however not all HAIs are preventable. Although we are delighted with the success in achieving our targets for MRSA and C. difficile for 2009-10 we will not be complacent and reducing our MRSA and C. difficile rates even further will continue to be a top priority for the organisation. The targets for 2010-11 are even more challenging with eight cases of post-48 hours MRSA and 98 cases of post-72 hours C. difficile.

Where are we now?

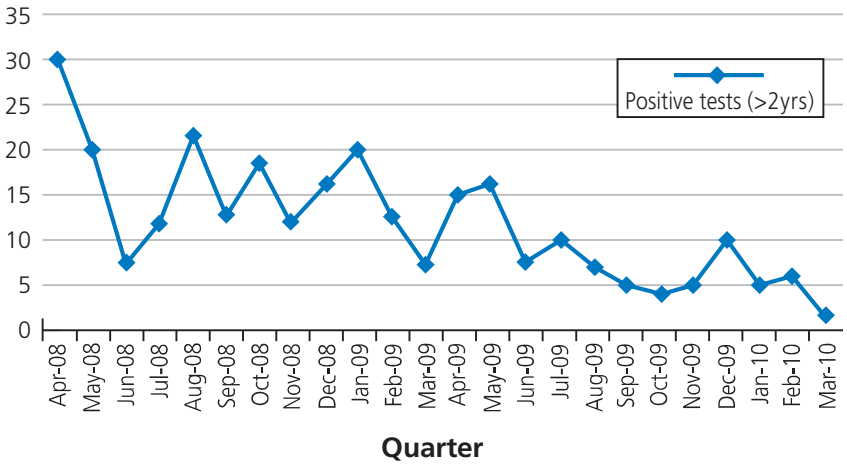
	2007/08 Actual	2008/09 Actual	2009/10 Actual	% change
MRSA bacteraemias	37	33	20	40
For MRSA we met our target of 20 cases for the twelve months. This represents a 40% reduction in numbers from 2008-9 when we recorded 33 cases.				✔
Clostridium difficile		192	93	56
For C. difficile we recorded 93 cases post 72 hours against a trajectory of 210, which is 56% below trajectory.				✔

How we have performed over time?

CHS MRSA bacteraemia 2001 - 2010



CHS positive C. difficile tests (>2yrs)



Improvements achieved

- Our self assessment against the Health and Social Care Act 2008 has shown that we are compliant in all areas.
- Success of our Infection Control Ward (F62) in managing patients with C. difficile infection and viral gastroenteritis. Our C. difficile infection rates are consistently below trajectory.
- We have introduced universal screening of all emergency admissions more than two years ahead of the Department of Health's guidance.
- We have developed a web-based infection control dashboard which will provide near real time information on infection control performance for individual directorates and departments.
- We now have an active group of Infection Control Clinical Champions who provide a focus for identifying and implementing infection control measures specific to their directorates.
- We continue to carry out root cause analysis of all MRSA bacteraemias at board level. Lessons learned are disseminated widely and are further cascaded to the shop floor by our Clinical Champions.

Further improvements identified

- Redefine and extend the role of the Infection Control Ward F62 to include all patients who pose an infection risk.
- Set up a programme to start monitoring MRSA bacteraemias and introduce screening for MRSA in high risk groups such as renal dialysis patients and patients undergoing implantation of a prosthetic device.
- Introduce a new real-time bed management system to better manage beds and track patients who are subsequently known to be an infection risk.
- Increase availability of infection control packages for staff using E-learning.
- Continue to develop and empower those staff undertaking Clinical and Hand Hygiene Champion roles in wards and clinical areas.

Priority 2:
To increase the percentage of patients treated in a dedicated stroke unit

There are approximately 150,000 strokes in England each year. Stroke is the third largest cause of death in the UK, responsible for 11% of deaths in England, and the largest cause of adult disability. Stroke Units are known to save lives and reduce disability.

The annual national sentinel audit of stroke originally set a target of more than 50% of patients staying on a stroke unit. New national "must-do's" (DH 'vital signs') have set a more challenging stroke target and look at the proportion of people who spend at least 90% of their time on a stroke unit. The national stroke strategy states that where patients spend at least 90% of their time on a stroke unit, patients achieve better outcomes in terms of their independence and ability to return home.

For 2009-10 this metric formed part of our Commissioning for Quality and Innovation (CQUIN) scheme, a new national framework which makes a proportion of our income conditional on achieving an agreed set of quality and innovation goals.

Where are we now?

National Sentinel Stroke audit - % of patients	City Hospitals score	National median
2004 - target set 'more than 50% of stay'	45	40
2006 - target set 'more than 50% of stay'	77	58
2008 - target set 'patients treated for 90% of stay'	41	56

	2008/09 Actual	2009/10 Actual	% change
% Patients spending 90% on a stroke unit	41%	60%	19%
For Stroke patients, the Trust significantly improved its performance compared to 2008/09, but fell just short of achieving the CQUIN target of 65% of 210, which is 56% below trajectory.			✔

Improvements achieved

- Increased the capacity of the Stroke Unit.
- Additional rehabilitation beds and associated medical care.
- Additional consultant wards rounds on the Stroke Unit.
- Integration of a new community based rehabilitation stroke team.

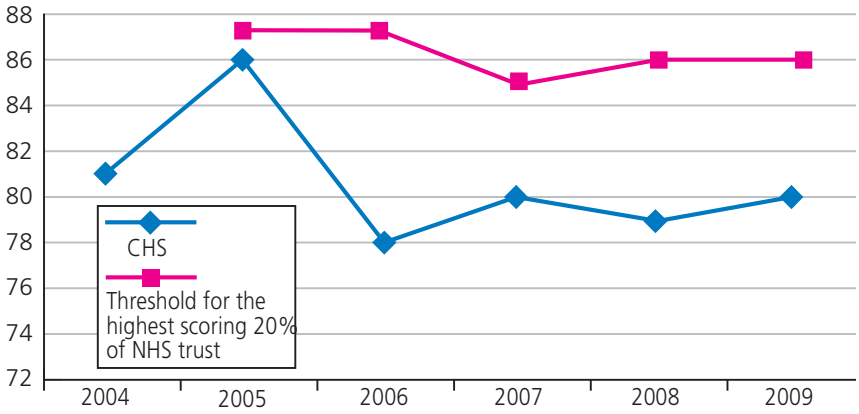
Further improvements identified

- Opening of a new dedicated stroke unit with additional stroke beds.
- Refinement of the stroke pathway in line with the National Stroke Strategy.
- A stroke 'bundle of care' will be included in the CQUIN scheme 2010/11.

Priority 3: Improve the patient's (self-reported) experience of pain

The National Inpatient Survey provides the trust with an annual snapshot of patient experience and satisfaction. The programme remains one of the biggest assessments of the views of patients on the treatment and care they receive whilst in hospital. Results from previous inpatient surveys (2004-2007) have shown that patients are concerned about management of their pain.
Our aim was to increase the percentage of patients who feel that hospital staff did everything they could to help control their pain.

Where are we now?



The results of the National Inpatient Survey 2009 show a slight improvement to the overall benchmarking score, from 79 in 2008 to 80 in 2009, the threshold for the highest scoring 20% of NHS Trusts remaining the same.

CHS patient experience survey 'How Well Did We Do?' was initially developed as part of the 'Time to Care' project and subsequently rolled-out Trust wide. The project fits in with the strategic vision of the Trust in creating the ideal patient experience by improving care processes and reducing waste on wards in order to increase the time nurses have to deliver safe, reliable and quality care. The aim of the near real-time survey was to give hospital patients an opportunity to express their views and opinions anonymously and rate their overall experience. One of the questions asked was
"Did staff do everything they could to manage your pain?" Overall the scores suggest an improvement across both Time to Care (average 93%) and Non-Time to Care (91%) wards.

Improvements achieved

- A new trust-wide multidisciplinary pain management group.
- Capture of near real-time feedback on patients' pain experience.
- Completion of internal pain management survey 2009.
- Addition of pain assessment scores on the new clinical observation (vital signs) chart.

Further improvements identified

- Increase the percentage of patients who have a pain score documented on admission.
- Introduce measures to reduce the number of omitted and delayed analgesia.

Other priorities we agreed to report progress on include:

Patient safety					
Metric	Description	2008/09 Actual	2009/10 Actual	Change	Source
Hospital falls	Number of falls Rate of falls per 1,000 bed days	503 (1.7%)	630 (2.15%)	+127 (+ 0.45%)	Incident reporting system
Lower rate indicates better performance (however our reporting rates have also increased which is normally a sign of a better safety culture)					
Occurrence of 'Never Events'	Number of reported 'never events' as defined by NPSA	5	1	-4	Internal incident reporting system
Lower number indicates better performance					

The 'Never Events' reported are all wrong site surgery incidents occurring in two clinical directorates. All incidents have undergone root cause analysis to identify contributing factors and lessons which need to be learnt. Each clinical team has reported back to the Trust Clinical Governance Steering Group on actions taken to improve the safety of patients. We can also report that we have fully implemented the WHO Safer Surgery Checklist and will be auditing practice in 2010.

Clinical Effectiveness					
Metric	Description	2008/09 Actual	2009/10* Actual	Change	Source
Patient Reported Outcome Measures (PROMs)	Clinical outcomes of NHS servicesfrom the patients perspective – linkage rates **	N/A N/A	Varicose Veins – 84.9% Groin surgery – 86.4%	N/A	NHS Information Centre
Higher % indicates better performance * April – November 2009 ** excludes Hip & Knee replacement – full set of data is not available from the NHS Information Centre					
Fractured neck of femur	% of patients operated on within 48 hours	91.60%	92.95%	+1.35%	Performance & Information Services
Higher % indicates better performance					

Patient Experience					
Metric	Description	2008/09 Actual	2009/10 Actual	Change	Source
Mixed sex accommodation	Patient perception				
"Did you ever share a sleeping area with patients of the opposite sex?" "Did you ever use the same bathroom or shower area as patients of the opposite sex?"		88 (87*) 78 (80*)	91 (91*) 79 (85*)	+3 +1	Annual Inpatient Survey 2009
Higher number indicates better performance, i.e. percentage of patients who reported 'No' they did not					
Overall patient satisfaction	"Overall how would you satisfaction rate the care you received" (% of patients who said 'Good' and above)	77 (81*)	77 (81*)	No change	Annual Inpatient Survey 2009
Higher number indicates better performance (* threshold for the highest scoring 20% of NHS Trusts)					

Priorities for improvement 2010/11

In order to identify the top priorities for quality improvement in 2010/11, the Trust's Clinical Governance Steering Group considered performance on patient safety, patient experience and clinical effectiveness and in conjunction with the Trust's Executive Board, agreed the following priorities:

Priority 1: To further reduce the rates of avoidable hospital acquired infection

Priority 2: To improve patient and family experience and overall satisfaction

Priority 3: To reduce the number of slips, trips and falls and associated harm

Priority 1: To further reduce the rates of avoidable hospital acquired infection

Description of issue and rationale for prioritising

Hospital acquired infections (HAI) are infections that are neither present (nor incubating) when a patient enters hospital. About 9% of inpatients have a hospital-acquired infection, however not all HAIs are preventable. Reducing infections such as MRSA and Clostridium difficile is a top priority for the Trust. Evidence shows that this is one of the most important factors influencing confidence in care that patients consider prior to admission to hospital.

Aim/Goal

The Trust has a challenging target of not exceeding 8 post-48 hours MRSA bacteraemias for 2010/11.

How progress will be	
Measured	• Number of reported and confirmed cases of MRSA bacteraemias
Monitored	• Director of Infection Prevention & Control (DIPC)/ Infection Control Doctor / Head of Performance • Winning Ways Implementation Group • Clinical Governance Steering Group
Reported	• Corporate dashboard • Monthly to Clinical Governance Steering Group • The Board of Directors

Replacement knee joints

Priority 2:
To improve patient and family experience and overall satisfaction

Description of issue and rationale for prioritising

From an aggregated review and analysis of reported incidents, complaints and claims we know that there are some recurring themes which affect the hospital experience of our patients and their families which we need to address. There have also been some concerns raised, following investigations and inquests, where patients have unexpectedly died. Furthermore our continued participation in the annual national patient survey programme, in addition to our own local satisfaction surveys, plus local feedback from forums such as LINKs has raised some common issues that matter to patients. We will take account of this information and feedback, and improve the patient and family experience in certain key areas.

Aim/Goal

- The Trust will improve its performance across a range of patient experience measures, including dignity and respect, pain management, choice of food and assisting patients to eat, cleanliness of rooms or wards and the overall rating of care.

Other areas reflect aspects of clinical care and communication with patients and their families, including;

- Reducing the number of incidents and complaints relating to handover of care issues.
- Improving the recording and recognition of, and response to, clinical observations (vital signs), particularly in those patients whose condition is deteriorating
- Improving the methods of communicating treatment and clinical monitoring plans for patients
- Improving communication and supportive documentation with patient and carers around outpatient appointments
- Improving the standards of clinical record keeping
- Providing more frequent opportunities to speak with families about patients ongoing condition and treatment, particularly at the end of life or when the patients condition suddenly deteriorates

How progress will be	
Measured	• Patient experience measures - National Patient Survey 2009/10 • Real-time patient feedback • Number of reported incidents • Numbers of formal complaints
Monitored	• Monthly real-time feedback reports • Quality Review (Monthly) meetings
Reported	• Reports to Clinical Governance Steering Group • Reports to Executive Board / Board of Directors • Annual Inpatient Survey 2009

Priority 3:
To reduce the number of slips, trips and falls and associated harm

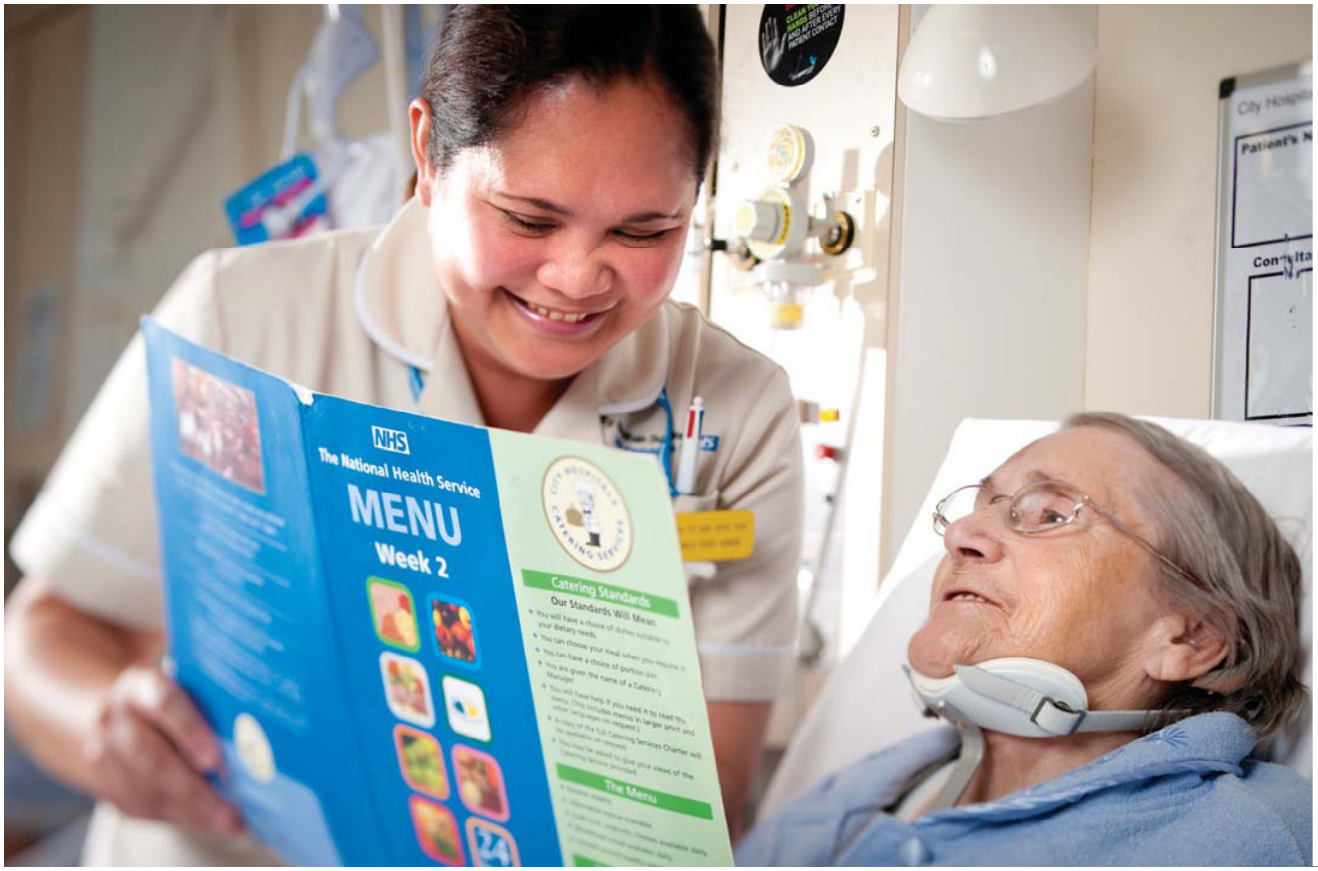
Description of issue and rationale for prioritising

"Falls", i.e. where a patient has accidentally fallen, are nationally the most reported safety incident and occur in all adult clinical areas. They occur at an average frequency of 4.8 per 1,000 bed days in acute hospitals and are estimated to cost the NHS £15 million every year. At City Hospitals falls is our top most reported clinical incident.

Aim/Goal

To reduce the incidence of patient falls by 10% and the number of incidents resulting in moderate, major and catastrophic injury.

How progress will be	
Measured	• CHS Incident reporting system
Monitored	• Quality Review (Monthly) meetings
Reported	• Reports to Clinical Governance Steering Group • Reports to Executive Board / Board of Directors



Statements of assurance from the board

Information on the review of services

During 2009/10 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 58% of these NHS services. The mechanism for review is via our internal 'Clinical Governance Review' which we introduced last year with the process overseen by the Clinical Governance Steering Group (CGSG).

According to a two yearly programme, Directorates and specialties are required to submit to CGSG a comprehensive progress review of their clinical governance and quality improvement activities. Based on the evidence submitted a decision is made on whether the service has 'earned autonomy', i.e. achieved an acceptable level of good governance and self-improvement. The new system offers light-touch reward for those doing well but provides a mechanism for regular review, engagement and support for those which are under-performing. The programme of review continues for the remaining service areas in 2010/11.

The income generated by the NHS services reviewed in 2009/10 represents 51% of the total clinical income generated from the provision of NHS services by City Hospitals Sunderland for 2009/10.

Participation in clinical audits and national confidential enquiries

During 2009/10 23 national clinical audits (part of the National Clinical Audit and Patient Outcomes Programme NCAPOP) and 5 national confidential enquiries covered NHS services provided by City Hospitals Sunderland.

During 2009/10 City Hospitals Sunderland participated in 96% of the national clinical audits and 100% of the national confidential enquiries for which it was eligible.

The national clinical audits and national confidential enquiries for which City Hospitals was eligible during 2009/10 are listed overleaf. The list also includes those in which we participated and for which data collection was completed during 2009/10, 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. However in a number of audits the data collection is on a continuous cycle.

National Confidential Enquiries Programme 2009 - 10			
Confidential Enquiry	Eligible for participation	Participation	Compliance
Parenteral Nutrition	✔	✔	100%
Emergency and Elective Surgery	✔	✔	100%
Surgery in the Elderly	✔	✔	To date
Peri-Operative Care	✔	✔	To date
CEMACH National Head Injury	✔	✔	To date

National Clinical Audit and Patient Outcome Programme 2009 – 10			
National Clinical Audits	Eligible for participation	Participation	Compliance
Cancer			
Bowel Cancer (NBOCAP)	✔	✔	Continuous data collection
Head & Neck Cancer (DHANO)	✔	✔	Continuous data collection
National Lung Cancer Audit (NLCA)	✔	✔	Continuous data collection
Oesophago-gastric Cancer	✔	✔	Continuous data collection
Mastectomy and Breast Reconstruction	✔	✔	Continuous data collection
Women and Children			
National Neonatal Audit	✔	✔	Continuous data collection
Paediatric Intensive Care Audit Network PICANet	N/A	N/A	N/A
Heavy Menstrual Bleeding	✔	Audit start still to be decided	
Epilepsy 12	✔	Audit to commence Autumn 2010	
Heart			
Adult Cardiac Surgery	N/A	N/A	N/A
Congenital Heart Disease (including paediatric surgery)	N/A	N/A	N/A
Coronary Interventions	✔	✔	August 2009 94%
Myocardial Ischaemia (MINAP)	✔	✔	April 2010 99.5%
Cardiac Ambulance Service	N/A	N/A	N/A
Heart Rhythm Management	✔	✔	Continuous data collection
Heart Failure	✔	✔	Unknown
Long-Term Conditions			
National Audit of Diabetes	✔	✘	
National Diabetes Inpatient Audit	✔	100%	
Renal Services - transport audit	✔	✔	Unknown
National Joint Registry	✔	✔	Continuous data collection
Inflammatory Bowel Disease	✔	Audit to commence Sept 2010	
Pain Database	✔	✔	100%
Mental Health			
Dementia	✔	✔	Data collection in progress
Psychological Therapies	N/A	N/A	N/A
Treatment Resistant Schizophrenia	N/A	N/A	N/A
Older People			
Stroke: Organisational	✔	✔ April 2010	100%
Carotid Interventions (UKCIA)	✔	✔	Continuous data collection
Services for People who Have Fallen	✔	Audit to commence Sept 2010	
Continence	✔	✔	100%
Hip Fracture Database	✔	✔	Continuous data collection

The reports of 12 national clinical audits were reviewed in 2009/10 and City Hospitals intends to take the following actions to improve the quality of healthcare provided.

Stroke

- The development of a protocol with the North East Ambulance Service (NEAS) which will ensure that all suitable patients believed to have had a stroke will be directed to the dedicated Stroke Unit Assessment Bay on the Acute Medical Unit.
- Development of a new Acute Stroke Unit with a staged increase in beds from 27-40 and the introduction of centralised continuous monitoring.
- An increase in the number of nursing staff from 10.2 per 10 stroke beds to 10.9.
- The appointment of a second Stroke Specialist Nurse.
- The development of a Stroke Patient Pathway to ensure that patients who require a stroke bed are admitted to the Stroke Unit.
- The implementation of a Community Stroke Team with a multidisciplinary approach.
- The reinforcement of MOMENTUM, a programme for vocational or return to work training for patients who have had a stroke.
- The development of an accredited continuing education and professional development programme for nursing staff in the management of stroke.
- The increasing involvement of patients/carers in the formulation of policy through the City-wide Stroke Implementation Group.

Falls and Bone Health in Older People

- Improvement in the falls patient pathway following collaborative work between primary and secondary care.
- Development of a standardised HISS based risk assessment, including a screening tool for all patients over the age of 16 years, with a more comprehensive tool for those who have actually fallen.
- The introduction of electronic risk reporting which allows areas to add more detail regarding the fall enabling robust reports regarding trends and themes across the organisation.
- Introduction of a falls e-learning package for all staff groups.
- The development of a Falls Specialist Nurse role, based in CHS to support wards.

Local Clinical Audit

The reports of 147 local clinical audits were reviewed* in 2009/10 and City Hospitals intends to take the following actions to improve the quality of healthcare provided.

(* registered with the Clinical Governance Department).

- Standardising the approach to tapering of steroid medication for patients with chest problems.
- Development of a new insulin prescribing chart to promote safer prescribing practices for patients.
- Development of a new emergency clerking proforma for use across the Division of Medicine.
- Amendments to the protocol for insertion of pacemakers to further reduce the chance of infection and wire displacement.
- Development of a new electronic notebook of 'daily goals' for patients in the Integrated Critical Care Unit.
- Improvements to the system of electronic traceability of blood transfusion in the Maternity Department.

Information on participation in clinical research

The number of patients receiving NHS services provided by City Hospitals Sunderland who were recruited during that period to participate in research approved by a research ethics committee was 801.

Information on the use of the CQUIN framework

A proportion of City Hospitals Sunderland income in 2009/10, i.e. 0.5%, was conditional upon 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.

For 2009/10, approximately £1m of income was attached to the delivery of quality improvements through the CQUIN framework. The Trust achieved the vast majority of these goals and has received approximately 95% of CQUIN monies, £950k.

The full CQUIN scheme 2009/10 is highlighted below:

Incentive weighting	CQUIN indicator	Link to local/regional /national strategy	Achievement of target
20%	Monitoring and implementation of the full quality schedule	Local	✔
20%	Innovation: collaboration on pathway reform and implementation	Local	✔
4%	Patients smoking status and referrals to the stop smoking service	National public health strategy	✔
4%	Uptake of cardiac rehabilitation	National public health strategy	✔
4%	Pregnant women obese at booking in referred to the dietician	National public health strategy	✔
4%	Stroke patients managed within a dedicated stroke unit[1]	National	✘
4%	Older people having a nutritional assessment recorded[1]	National	✘
10%	Pre screening isolation rates	National	✔
10%	Participation in the national PROMS programme	National PROMS programme	✔
10%	Review of mortality	Local	✔
5%	Documentation of medication changes	Local	✔
5%	Provision of data in relation to timeliness of discharge summaries1	National	✘

[1] Targets were partially achieved, but not throughout the full year

Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from Peter Sutton, Head of Performance, Trust Headquarters, Sunderland Royal Hospital, Kayll Road, Sunderland SR4 7TP.

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

From April 2010 new essential standards of quality and safety were introduced across all health and adult social care services in England. By law NHS hospitals now have a responsibility to ensure that the treatment, care and support they provide meet essential standards that protect patient safety and respect individual dignity and rights. The Care Quality Commission will license NHS hospitals to provide treatment, care and support if they meet these essential standards and will undertake continuous monitoring to check that essential standards continue to be met. NHS hospitals are the first to come into the new system which started in April 2010.

City Hospitals Sunderland is required to register with the Care Quality Commission and its current registration status is highlighted below.

Activities that the trust is registered to carry out	Status	Condition apply
Assessment or medical treatment for persons detained under the Mental Health Act 1983	✔	No conditions apply
Diagnostic and screening procedures	✔	No conditions apply
Family planning	✔	No conditions apply
Maternity and midwifery services	✔	No conditions apply
Surgical procedures	✔	No conditions apply
Termination of pregnancies	✔	No conditions apply
Treatment of disease, disorder or injury	✔	No conditions apply

City Hospitals Sunderland has no conditions which apply to its registration.

The Care Quality Commission has not taken enforcement action against City Hospitals Sunderland during 2009/10.

City Hospitals Sunderland is not subject to periodic review by the Care Quality Commission.

City Hospitals Sunderland has participated in the following special reviews or investigations by the CQC during the reporting period.

Hygiene Code

The CQC made an unannounced visit to the Trust on the 28 October 2009 and reported that :

"On inspection, we found no evidence that the Trust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare associated infection. Of the 15 measures we inspected, we had no concerns. For this inspection, we:

- Analysed information on how the Trust manages infection prevention and control, such as its risk registers, the frameworks used to assure the board that plans are happening in practice and the results of audits.
- Examined policies and procedures.
- Visited: the Acute Medical Unit, Ward D43 (trauma and orthopaedics) and Ward E51 (care of the elderly).
- Had discussions with the chief executive, the director of nursing, the medical director, the head of estates, the head of pharmacy, the lead clinical pharmacist, a consultant microbiologist, the hotel services manager, the facilities manager, matrons, ward managers, nursing staff, domestic staff and junior doctors."

The Trust hosted a Confirm, Challenge and Celebrate meeting with the Department of Health HCAI Improvement Team on the 8 December 2009 and were provided with assurance that the steps that we had taken with regard to infection control were now sufficiently embedded within the organisation that no further input from them was required.

Case reviews of deaths from non-infectious gastroenteritis

In July 2009 City Hospitals received a report from the Dr Foster Unit at Imperial College (DFU) indicating from their analysis of mortality data a higher than average mortality rate for the diagnostic code 'non-infectious gastroenteritis' (ICD 10 code K52.9). We undertook a retrospective case note review of a sample of patient deaths with this diagnostic code and found no evidence of any serious issues relating to the quality of clinical care. However we did identify some areas where we have made changes to practice, i.e. joint audit with our Primary Care colleagues of hospital readmissions, management of patients with chemotherapy related neutropenia (low white cell count).

The Trust submitted its detailed report to the Care Quality Commission, Monitor and the Sunderland Teaching Primary Care Trust.

Information on the quality of data

City Hospitals Sunderland submitted records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was 99.9% for admitted patient care; 99.9% for outpatient care; and 98% for accident and emergency care, significantly above the national average.
- which included the patient's valid General Practitioner Registration Code was 100% for admitted patient care;100% for outpatient care; and 100% for accident and emergency care.

City Hospitals Sunderland score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 90%.

City Hospitals Sunderland was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 9.3%.The national average in 2008/09 was 8.1% and the North East SHA average error rate was 12%. A combination of national changes to the rules and regulations of coding and internal staffing issues and high workload at the time affected our coding performance compared with previous years, i.e. in 2007/08 the error rate was 3.1% and in 2008/09 1.8%.

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. For example, the audit focused on the national theme of General Medicine (100 records), Respiratory Medicine (100), some cardiac procedures (70) and a small group of non-traumatic minor hand procedures (30).

An action plan has been agreed to improve performance which will be monitored by the joint Sunderland PCT / City Hospitals Contracting Group.

> "On inspection, we found no evidence that the Trust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare associated infection."

Part 3. Other information

Overview of quality performance 2009/10

We have chosen to measure our performance against the following metrics	2007-08	2008-09	2009-10	National average / Peer Group
Safety measures reported				
1. Patients with blood borne MRSA infection	37 (target 22)	33 (target 25)	20 (target 20)	N/A
Lower value indicates better performance Data source - Trust MRSA data reported to the Health Protection Agency (HPA)				
2. Patients with C-difficile infection (post 72 hours cases)	N/A (target 270)	192 (target 210)	93	N/A
Lower value indicates better performance Data source - Trust C.diff data reported to the Health Protection Agency (HPA)				
3. Clinical incidents reported per 100 admissions	N/A	2.89	5.2	Median 5.40
Organisations that report more incidents usually have a better and more effective safety culture Data source - Organisation Patient Safety Incident Report (1st April 2009 – 30th September 2009), National Patient Safety Agency (NPSA)				

We have chosen to measure our performance against the following metrics	2007-08	2008-09	2009-10	National average / Peer Group
Clinical outcome measures reported				
4. Hospital Mortality Risk Adjusted Mortality Index (RAMI 2008)	81	84	82	Peer 84
Lower value indicates better performance Data source - CHKS 'Signpost' system				
5. Readmission rates	5.6%	5.8%	6.0%	6.0%
Lower % indicates better performance Data source - CHKS 'Signpost' system				
6. Patients with fractured neck of femur operated on within 24 hours of admission	83%	83%	82.3%	N/A
Higher % indicates better performance Data source - internal Trust data (1st April 2009 – 28th Feb 2010)				

We have chosen to measure our performanceagainst the following metrics:	2007	Threshold for best 20%	2008	Threshold for best 20%	2009	Threshold for best 20%
Patient experience measures reported						
7. Patients who felt they were treated with dignity and respect	88	90	89	90	88	90
Higher scores indicates better performance Data source – Annual Inpatient Survey						
8. Patients involved as much as they wanted to be in decisions about their care	71	73	73	74	71	74
Higher scores indicates better performance Data source – Annual Inpatient Survey						
9. Patients who rated their care	77	80	77	81	77	81
Higher scores indicates better performance Data source – Annual Inpatient Survey						

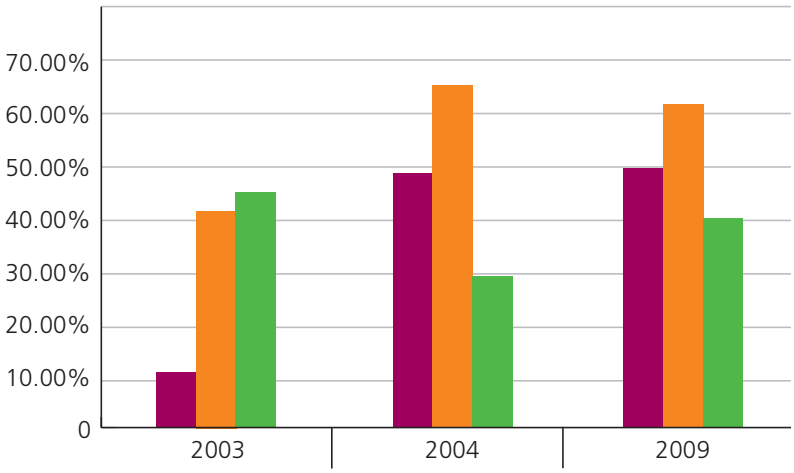
Notes on patient experience measures

The scores included in the table above are benchmark scores rather than percentages, calculated by converting responses to particular questions into scores. For each question in the survey, the individual response was scored on a scale of 0 to 100. The higher the score for each question, the better the Trust is performing.

National Outpatients Survey 2009

City Hospitals took part in the third National Outpatients Survey which forms part of the wider national programme of NHS patient surveys. People were eligible for the survey if they were aged 16 years or older and attended a recent outpatient department. In total we had 567 responses and a response rate of 67% compared with the national average of 63%. Overall scores are very good and reflect the high quality of service provided by outpatients. The Trust only recorded 1 red rating (choice of appointment times) and the proportion of green ratings has increased from 29.30% in 2004 (the last survey) to 52.50% this year.

Table 1 shows the distribution of category ratings for the surveys completed 2003 – 2009



	2003	2004	2009
■	11.40%	48.00%	2.50%
■	42.90%	65.90%	45.00%
■	45.70%	29.30%	52.50%

PEAT (Patient Environment Action Team) 2009

PEAT 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). It is designed to ensure that improvements are made in the non-clinical aspects of a patient's experience.

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 results of the 2009 assessment are highlighted below:

Year	Results		
	Environment	Food	Privacy and dignity
2009	✔ Excellent	✔ Excellent	✔ Excellent

Delivering Same Sex Accommodation

In March 2010, City Hospitals undertook a self-assessment of the provision of same sex accommodation and declared compliance with the commitment to virtually eliminate mixed sex accommodation. A plan is in place to ensure continued delivery and improvement of same sex accommodation during 2010/11.

Patient Safety

The Trust continues to take a full and active part in the national and local (Safer Care North East) patient safety agenda.

- In the Dr. Foster publication 'How Safe is Your Hospital?' (December 2009) we achieved a patient safety banding of 4 (1 for the poorest performers and 5 for the best). The score is a combination of different measures which gives a more 'rounded' view of hospital performance on patient safety.
- The Trust has been successful in joining the Leading Improvements in Patient Safety (LIPS IV) programme. The national programme aims to help NHS trusts develop plans for patient safety improvements and to build teams with the passion, skills and confidence to drive improvements at every level of the organisation. The LIPS programme has the full support, and participation, of the Board.
- Throughout the year we have been working with colleagues to implement the national WHO Safer Surgical Checklist (NPSA). The checklist is designed to reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying and checking essential care interventions. An audit to assess compliance will take place later in the year.
- In a related development which played a key role in the implementation of the Safer Surgical Checklist, a large number of clinical and managerial staff have undergone human factors teamwork training. Atrainability, who are acknowledged as experts in the field, provided support and coaching to staff working in the surgical and operating environment to improve team working and interaction.
- We formally launched the 'ThinkGlucose' campaign in March 2010 to a clinical audience of over 150 staff. ThinkGlucose is a major programme from the NHS Institute, designed to improve the management of people with diabetes and their experience of care when they are admitted to hospital.
- City Hospitals is currently participating in a major national patient safety research programme. The Newcastle based study is one of four complementary projects that aims to get patients involved in patient safety. Our specific work will be looking at developing and evaluating a range of approaches to encourage patients to engage with staff in improving safety in high risk areas.
- Development of a new e-learning package for staff on promoting improved falls assessment and management practices. It is expected to be launched in early summer 2010.

Rule 43

During 2009/10, we received two Rule 43 notices from the Coroners Office in cases where he believed urgent action should be taken to prevent future deaths. As an organisation we have a duty to ensure that all the concerns expressed by the coroner are acted upon to improve practice and patient safety. Some of the issues highlighted and identified in our action plans include improvements to standards of record keeping, better systems of communication and handover of care, timely recording and acting on patients' observations and breaches of Trust policy and protocols. Progress of these action plans will be monitored by the Clinical Governance Steering group.

> "As an organisation we have a duty to ensure that all the concerns expressed by the coroner are acted upon."

Performance against key national priorities and National Core Standards

Performance against key patient targets

During 2009/10 the Trust delivered the vast majority of key national priorities, including the extremely challenging MRSA and A&E targets. There were only 3 areas where the Trust performed slightly below the required standards, Infant Health, Cancer and Stroke. These targets have been rated 'amber' given that the Trust was only marginally below each of the respective targets, and some parts of the target were achieved. It is also likely that the Care Quality Commission will rate these areas as 'under-achieved', but not 'failed' as they are close to achieving their respective goals.

Outpatients Survey which forms part of the wider national programme of NHS patient surveys. People were eligible for the survey if they were aged 16 years or older and attended a recent outpatient department. In total we had 567 responses and a response rate of 67% compared with the national average of 63%. Overall scores are very good and reflect the high quality of service provided by outpatients. The Trust only recorded 1 "red" rating (choice of appointment times) and the proportion of "green" ratings has increased from 29.30% in 2004 (the last survey) to 52.50% this year.

Table 1 shows the distribution of category ratings for the surveys completed 2003 – 2009

Indicator	Last Year 2008/09	Target 2009/10	YTD 2009/10	YTD Variance	YTD
Quality/Safety Metrics					
Infant Health - smoking during pregnancy	22.95%	22.94%	22.93%	-0.01%	
Infant Health – breastfeeding	50.71%	51.72%	48.69%	-3.03%	
Stroke Care - >=90% LOS on stroke unit	30.00%	70.00%	60.00%	-10.00%	
Data quality on ethnic group	96.44%	>95.00%	95.63%	0.63%	
Maternity Data Quality		90.00%	97.28%	7.28%	
Delayed discharges	0.92%	<2.00%	1.72%	-0.28%	
18 Week RTT - admitted patients	90.72%	90.00%	96.36%	6.36%	
18 Week RTT - non admitted patients	95.92%	95.00%	99.04%	4.04%	
Cancer waits - seen <=2 weeks from referral	95.63%	93.00%	93.73%	0.73%	
Cancer waits - seen <=2 weeks from referral for breast symptoms	91.18%	93.00%	96.53%	3.53%	
Cancer waits – treated <=31 days	99.76%	96.00%	98.48%	2.48%	
Cancer waits - subsequently treated <=31 days	99.14%	98.00%	98.30%	0.30%	
Cancer waits – treated <=62 days from referral	82.84%	85.00%	84.47%	-0.53%	
Cancer waits – treated <=62 days from screening	100.00%	90.00%	92.86%	2.86%	
A&E waits - admitted or discharged <4 hours	98.62%	98.00%	98.00%	0.00%	
Cancelled operations - % total elective workload	0.50%	<=0.80%	0.54%	-0.26%	
Incidence of BB MRSA	33	<=20	20	0.0	
Incidence of C-DIFF	192	210	93	-117.0	

Compliance with Core Standards (Care Quality Commission)

The Trust was fully compliant against all 43 core standards throughout 2009/10. Following the Trust's self-declaration, the Care Quality Commission validated the statement using a range of external information and intelligence. No concerns were found over the Trust's statement and the Trust did not receive a Care Quality Commission inspection.

The following tables show the compliance status displayed against each of the core standards for 2008/09 and this is replicated for 2009/10, although not published yet.

Safety	2008/09
C01a - incidents - reporting and learning	● COMPLIANT
C01b - safety alerts	● COMPLIANT
C02 - safeguarding children	● COMPLIANT
C03 - NICE Interventional procedures	● COMPLIANT
C04a - infection control	● COMPLIANT
C04b - safe use of medical devices	● COMPLIANT
C04c - decontamination	● COMPLIANT
C04d - medicines management	● COMPLIANT
C04e - clinical waste	● COMPLIANT
Clinical and cost effectiveness	
C05a - NICE technology appraisals	● COMPLIANT
C05b - clinical supervision	● COMPLIANT
C05c - updating clinical skills	● COMPLIANT
C05d - clinical audit and review	● COMPLIANT
C06 - partnership	● COMPLIANT
Governance	
C07a and c - governance	● COMPLIANT
C07b - honesty, probity	● COMPLIANT
C07e - discrimination	● COMPLIANT
C08a - whistle-blowing	● COMPLIANT
C08b - personal development	● COMPLIANT
C09 - records management	● COMPLIANT
C10a - employment checks	● COMPLIANT
C10b - professional codes of conduct	● COMPLIANT
C11a - recruitment and training	● COMPLIANT
C11c - professional development	● COMPLIANT
C12 - research governance	● COMPLIANT

Patient focus	2008/09
C13 - dignity and respect	● COMPLIANT
C13b - consent	● COMPLIANT
C13c - confidentiality	● COMPLIANT
C14a - complaints procedure	● COMPLIANT
C14b - complainants discrimination	● COMPLIANT
C14b - complaints response	● COMPLIANT
C15a - food provision	● COMPLIANT
C15b - food needs	● COMPLIANT
C16 - accessible information	● COMPLIANT
Accessible and responsive care	
C17 - patient and public involvement	● COMPLIANT
C18 - equity, choice	● COMPLIANT
Care environment and amenities	
C20a - privacy and confidentiality	● COMPLIANT
C21 - clean, well designed environment	● COMPLIANT
Public Health	
C22a and c - public health partnerships	● COMPLIANT
C22b - local health needs	● COMPLIANT
C23 - public health cycle	● COMPLIANT
C24 - emergency preparedness	● COMPLIANT

Annex. Statement from Sunderland Local Involvement Network (LINk)

"Sunderland LINk feels that the Trust's Quality Account is broadly representative of the quality of service provided by the Trust and gives a comprehensive coverage of the services delivered. They also feel that the information contained in the Quality Account seems accurate and they do not feel that there are any significant omissions or issues of concern. The LINk recognises that the information contained in this report is prescribed by the regulations for quality accounts and the presentation of the information in a public friendly format is difficult.

LINk members have suggested the inclusion of case studies to illustrate real life examples as ways to improve the usefulness of the report for the public. The terminology used in describing reductions in infections is very technical and not generally public friendly. This LINk commends City Hospitals' efforts in reducing the incidence of MRSA and C.difficile infections and their challenging target to reducing them even further so they are aligned with national expectations.

The LINk also considers the Trust's efforts to focus quite closely on specific targets to improve the patient experience regarding pain and how the staff deal with a person's pain an appropriate target. Each person's experience of pain is different, however the manner in which the pain is resolved is crucial to the person's experience whilst in the hospital.

The issue of dignity and respect has been highlighted in a recent conference held by LINk and will support the Trust's efforts to improve the overall patient and family experience and provide independent feedback to the Trust on a regular basis.

I hope the Trust will find the comments helpful. We look forward to working with you during the coming year to be able to contribute fully with next year's Quality Account".

Michael McNulty

MICHAEL MCNULTY

Chair – Sunderland LINk

Ken Bremner, Chief Executive signed Mencap's 'Getting it right' charter to improve the rights of people with a learning disability to equal healthcare.

Annex. Statement from 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. NHS South of Tyne and Wear takes this responsibility very seriously and considers this to be an essential component of the commissioning function. There are well established mechanisms in place with local foundation trusts to monitor the quality of the services provided and to encourage continuous quality improvement. These mechanisms are regularly reviewed and developed in the light of local and national recommendations; for instance the monitoring of mortality rates and patient experience have been strengthened in the past year following recommendations from the Care Quality Commission.

NHS South of Tyne and Wear has monthly quality and contract review meetings with City Hospitals Sunderland Foundation Trust 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. complaints reports
- review and discuss relevant external reports e.g. Care Quality Commission patient surveys
- monitor action plans arising from the above reports
- monitor performance against national targets

In addition to the above a Non-Executive Director from Sunderland Teaching PCT takes part in infection control visits at City Hospitals Sunderland. The PCT was also involved in a peer review of the Trust's arrangements to deliver single sex accommodation; there were several positive aspects to the visit and the Trust outlined further plans for improvement.

Much of the information contained within this Quality Account is used as part of the quality monitoring process described above e.g. infection control rates, performance against national targets, mortality data and achievement against CQUIN indicators. 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.

It is positive to note that the priorities for improvement in 2010/11 identified within the report closely align with NHS South of Tyne and Wear priorities that have been included in the 2010/11 CQUIN scheme with City Hospitals Sunderland Foundation Trust; this links 1.5% of the contract value to achievement of the CQUIN improvement goals.

Annex. Statement from Overview and Scrutiny Committee (OSC)

The Overview and Scrutiny Committee made no comment on the report this year because of other commitments which prevented detailed discussion.

OFR: PATIENT CARE

Performance Against Key Patient Targets

During 2009/10 the Trust delivered a number of significant performance improvements, all of which improved patient access to our services. The Trust maintained its existing high levels of performance in a number of key areas such as inpatient and outpatient waiting times and further improved performance in a number of other areas such as reducing the number of cases of MRSA and C.difficile.

Overall, the Trust has consistently been one of England's best performing Trusts, and this has been recognised again via the CHKS Top 40 Hospitals Awards.

Inpatients and Daycases

An increase in activity levels from 2008/09 did not prevent the Trust making reductions to the waiting time for non-emergency admissions. Throughout 2009/10 the Trust achieved the overall admitted and non-admitted targets in relation to the 18-week referral to treatment target and since October 2009 these were delivered across all specialties.

A priority for the organisation during 2009/10 was to reduce the length of stay (LOS) for both elective and non-elective (emergency) patients. For elective patients the Trust not only achieved, but surpassed its internal target to be in the top 10% of all Trusts against this indicator.

For non-elective patients, the focus was within Elderly Medicine and again LOS has been reduced in this area compared to 2008/09. A substantial amount of work has been done with our partners in Sunderland City Council's Adult Services during the year and this will continue during 2010/11 as we aim to improve the patient experience, whilst also reducing the patient LOS.

In relation to cancelled operations only 0.5% of all patients had their operation cancelled on the day of surgery, significantly below the national average.

As anticipated the Trust experienced significant pressures from increased emergency admissions over the winter period. The opening of contingency wards when necessary, and close working with other local providers ensured that all patients received high quality care.

Outpatients

Throughout 2009/10, the Trust continued to reduce its outpatient waiting time and the majority of specialties now operate a 6-week maximum waiting time for new referrals via the national Choose and Book system.

During 2009/10, over 97% of patients who required treatment in an outpatient setting were treated within 18-weeks from their referral, ensuring that the Trust surpassed the government target of 95%.

In 2010/11 the Trust will focus on patients who did not attend (DNA) for their appointment in order to further improve efficiency.

Diagnostics

One of the toughest targets for 2009/10 was to ensure that patients did not wait longer than 6-weeks for a diagnostic test. However, by the end of the financial year the target had been achieved and during 2010/11 work will continue to maintain this position going forward and further reduce waiting times.

Cancer

New cancer targets became 'live' during 2009/10 and mirror guidelines used for the 18-week measurement. During 2009/10 the Trust achieved and exceeded the targets in relation to seeing patients with a suspected cancer within 2 weeks and similarly that those patients diagnosed with cancer received their treatment within 31 days.

With respect to the cancer 62-day target the Trust narrowly missed achieving the government target of 85%, reporting just under at 84.5%.

Accident & Emergency (A&E)

Working in collaboration with primary care the Trust met the target that 98% of patients were discharged or admitted within four hours of attending A&E or a local Urgent Care Centre during 2009/10. Working with colleagues in the Teaching Primary Care Trust an Urgent Care Network has been established to review, and improve where possible, all urgent care services across the health community.

MRSA & C.difficile

The Trust had a target of a maximum of 20 cases of Blood Borne MRSA for 2009/10 and recorded exactly 20 cases for the twelve month period. This represents a 40% reduction from 2008/09 when the Trust recorded 33 cases.

For C.difficile the Trust recorded 93 cases post 72 hours against a trajectory of 210, which is 56% below target and a 52% reduction on the number of reported cases during the previous year.

Whilst this is good news for our patients we can never be complacent and will continue to work hard to drive down our infection rates even further.

The new self service check-in kiosks located in Outpatients were funded through the city wide Digital Challenge project.

ARRANGEMENTS FOR MONITORING IMPROVEMENTS

Organisation Arrangements

Clinical Governance continues to be at the centre of the Trust's policy to improve services to patients. The Clinical Governance Steering Group ensures that the Trust provides quality of care through a network of clinical governance leads and facilitators throughout the Trust.

During the year they have considered the following reports and findings.

Patient surveys

We know that listening and talking to our patients and their families provides valuable feedback, which helps to improve existing services and to develop new ones. It also identifies where individual needs and experiences have not been met and what more we need to do.

The Trust participated in the annual National Inpatient Survey 2008. Over 72,000 patients from 165 acute and specialist NHS hospitals in England took part, which remains one of the largest assessments of the views of patients on the treatment and care they receive whilst in hospital. Essentially the survey tries to answer the fundamental questions:

- Are we delivering on our goals in the eyes of our patients?
- What do patients perceptions tell us about their experiences?
- Where do we need to do better?

The survey captured the views and experiences of 470 patients who were discharged from City Hospitals. Once again, we had a mixed set of results compared with last year with 66% of scores occupying the middle ground. We did increase the number of top "green" ratings from 18% to 21%, and performed well in areas such as our admission process and discharge planning. Patients still remain confident about the doctors and nurses, are well informed and feel they are cared for with privacy and dignity. Disappointingly however, our red ratings also increased and once again the patients' perception is that we need to do more to improve the cleanliness of wards; more effort is needed to give patients a choice at mealtimes and additional help is required to better manage pain. Recent internal surveys, via the 'How Did We Do' questionnaire suggests that we have made progress with regard to improving the patient's pain experience. We hope that these positive findings are reflected in the Inpatient Survey 2009 soon to be published.

We performed far better in the 3rd national Outpatients Department Survey 2009, with an excellent set of scores reflecting the high quality of service provided by Outpatients. The Trust only recorded 1 "red" rating (choice of appointment times) and the proportion of the top "green" ratings almost doubled increasing from 29% in 2004 (the last survey) to 53% this year. Other nationally mandated patient surveys we have supported this year include Delivering Same Sex Accommodation and the national Choice programme.

The Trust also runs its own programme of local surveys linked to both clinical specialty and organisational requirements i.e. for peer review process. During 2009/10 we have completed over 40 individual surveys involving approximately 3,700 patients. These include such diverse areas as antenatal screening, occupational health, dietetic lifestyle, bariatric surgery, multiple sclerosis and pharmacy dispensing.

Below are brief summaries from some of the surveys completed:

- The Renal Unit surveyed patients about proposed changes to the dialysis appointment system. The new appointment system zones transport and appointment slots to specific areas aiming to reduce travel time and delays for patients waiting to get onto dialysis machines. As a result of the changes most patients commence their treatment within 30 minutes of their appointment time and they feel that the new system has improved their overall experience of the Renal Unit.

- Radiology surveyed patients who had recently attended their department for an x-ray. Most patients found the department efficient and clean (93%), were happy with staff attitude (93%) and in the majority of cases were told how they would receive their results (98%). However, a small number of patients waited longer than necessary for these results. The timeliness of patients receiving their x-ray results is currently being addressed.
- A survey of patients with urological cancer who had contact with their Specialist Nurse was undertaken to find out their views of the service. Patients rated their ongoing contacts very highly and made only a few negative comments, specifically about the timeliness of information and the sharing of results at consultation. The urology team have addressed these concerns and now have information booklets available for patients and changes have been made to the specialist nurse work timetable.
- Patients attending the Bariatric Department reported high levels of satisfaction with the service. They had confidence and trust in the doctors and nurses treating them; were offered the support of a dietician and were told who to contact after discharge. However they did have some concerns about the choice of food available and the information received. Revised menus and a new patient information leaflet are now available.

As part of the 'Time to Care' project to help increase direct time for nursing staff to care for patients and create the ideal patient experience, a new system of real-time feedback was introduced. This involved a team of volunteers visiting wards to help patients complete the 'How Did We Do' questionnaire. For the period June – August 2009 over 1,000 questionnaires were completed. Feedback to wards was provided by reports showing individual scores and performance against peers. The results of these surveys are available on ward 'Petals of Performance' boards, and are all on public view. The system of 'real-time' feedback will be developed in 2010 and we expect further lay involvement with the addition of Governors, members of the Community Panel and the Local Involvement Network (LINk) Group.

Clinical Audit

The Trust continues to take a full and active part in the national clinical audit programme as well as running its own programme of audit matching regional and local priorities. During 2009/10 we have taken part in key clinical priority areas such as stroke, diabetes, falls, continence care, heart disease and cancer. In addition, we have supported a further 139 audits which are registered on our internal database. Some of the changes made to policy and practice in City Hospitals as a result of our participation in audit are highlighted overleaf:

- In December 2009, an audit of readmissions via the Acute Medical Unit (AMU) was undertaken jointly with the Teaching Primary Care Trust. From our analysis a number of patients had readmissions linked to their hospital stay and others had an admission which could have been avoided altogether. There is a view that these patients could be better managed in the community with a range of support services. A joint action plan is being prepared by the Trust and the PCT, together with the involvement of the ambulance service and Adult Services.
- An Audit of the use of cortico-steroids in Thoracic Medicine resulted in a standardised approach to the tapering of steroid medication.
- As a result of an audit of inpatient diabetes care, there has been a new (safer) insulin prescribing chart developed which will be used across the Trust, and a new series of staff training days for the management of diabetes.
- Within Haematology an audit of neutropenic septic patients (infection of patients with a low white cell count), has led to the development of a new patient group directive (PGD) for the administration of the first course of antibiotics for this patient group.
- The daily audits undertaken in the Intensive Critical Care Unit (ICCU) replace several retrospective audits enabling practice to be changed quickly if any concerns are identified. The work enables "daily goals" to be agreed by a multi-disciplinary team. Work is now underway to develop an electronic notebook of this data which will be kept at the bedside. This will enable data to be collected at the point of treatment and shared with the multidisciplinary team.

- An audit of haemorrhage and use of the 'traceability system' for blood transfusions in Obstetrics showed some areas requiring improvement. As a result, special blood transfusion scanners have been deployed in the maternity theatre recovery area (as most of the transfusions are given in theatre). The maternity risk manager is now informed of any compliance issues by the blood transfusion laboratory.
- Following an audit of documentation (including the observation charts) in the Acute Medical Unit (AMU) a new medical clerking proforma has been developed for use across the Division of Medicine. The Deteriorating Patient Group is now looking at standardising the clerking proforma in the Division of Surgery.
- In Cardiology, following an audit of the pacing service changes have been made to the protocol to reduce the chances of infection and pace lead displacement.
- In the Emergency Department an audit was undertaken of standards of record keeping. The results showed some examples where documentation could be improved, particularly in relation to the use of recognised clinical assessment systems i.e. Wells Score, Glasgow Coma Score. As a result, it was agreed to develop an aide memoire for these types of scoring scales and other essential clinical information in the format/size of a credit card. The cards were developed initially for the Emergency Department but have now been rolled out to other specialties and to all junior doctors and nurse practitioners. There are plans to re-audit the use and effectiveness of the cards in 2010.

In September 2009, the winner of the second Clinical Audit Award was announced at the Trust's Reward & Recognition event held at the Stadium of Light. The overall winner was a team from Orthopaedics with their audit entitled:

"Hip fracture antibiotic prophylaxis: the outcomes of changing from a 3 dose cefuroxime regime to single dose gentamicin and amoxicillin"

The prize included a sponsored place at the NICE Conference 2009 in Manchester.

Complaints Handling

The Trust has an established complaints policy in line with the NHS complaints procedure, which seeks to ensure that patients, visitors and carers concerns are investigated and acted upon to improve the patient experience.

This is in line with the Parliamentary and Health Service Ombudsman's six key principles:

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

In April 2009, the revised legislation of the complaints procedure was implemented and the mandatory timescale for resolution of complaints was removed. This was to allow organisations to take a more flexible approach and to negotiate the response time with the complainant where feasible. However, the Trust made a decision to continue to work towards the existing twenty five working day timescale where this was felt to be achievable. For those cases which may be more complex, the timescale can be negotiated with the Directorate to allow additional time to ensure that a comprehensive investigation can be achieved.

In order to ensure that lessons are learned from complaints, a quarterly report is incorporated into the Directorate Clinical Governance reports and presented to the Clinical Governance Steering Group. This is an aggregate report, providing information relating to the activity of complaints, claims and incidents, which allows the Trust to identify any common themes and trends requiring further investigation and/or action.

During the period 1 April 2009 to 31 March 2010 the Trust received 442 formal complaints from patients or their representatives. This demonstrates a 5.4% increase from 2008/09, which is perhaps reflective of the Trust's overall increase in activity, particularly during the winter pressures.

Complaints Investigation

Formal complaints are assigned to an Investigating Officer within the Directorate, usually the Directorate Manager, who has responsibility for ensuring that a comprehensive investigation into the complaint has taken place and for implementing any service improvements as a result of the issues identified.

Following the Trust's written response, complainants are invited to contact the Investigating Officer if there are any outstanding issues which they would like to discuss further. If the complainant remains dissatisfied, a formal meeting with appropriate staff members would be offered for a more personal and open discussion, in an attempt to resolve their concerns.

Where complainants remain dissatisfied with local resolution, they have the opportunity to seek an independent review by the Parliamentary and Health Service Ombudsman.

In addition to the complaints department, the Patient Advice and Liaison Service (PALS) is available to provide advice and support to patients, relatives and/or carers. Part of their role is to deal with any minor concerns which can be resolved quickly and effectively and those issues where the patient/relative does not wish to make a formal complaint. During 2009/10, PALS received a total number of 635 contacts for advice and support.

As a result of complaints and patient feedback, a number of improvements to the services we deliver have been made which include:

- the introduction of smoking shelters for patients at two locations across the site to ensure that the main entrances to the hospital are now smoke-free;
- the provision of snacks on the wards for patients who have just had surgery and for those patients who are diabetic;
- the development of a training programme for nursing staff caring for patients diagnosed with Parkinson's disease to make them more aware of the problems such patients encounter;
- the installation of quiet rooms on some wards to enable staff to have a private area to be able to break bad news or to discuss issues of a delicate nature with patients and/or their relatives;
- ensuring that our Park and Ride bus service from a local supermarket and the Stadium of Light football stadium has disabled access; and
- reviewing the current training programme to highlight in particular how early intervention can prevent a complaint from becoming formal.

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 have developed good working relationships with our main commissioner the Sunderland Teaching Primary Care Trust which will be critical in the current environment of significant cost pressures and extremely limited financial growth.

The partnership working was very clearly identified during the pandemic flu outbreak in 2009. Very comprehensive command and control arrangements were put in place by the Strategic Health Authority across the North East patch. Weekly multi-agency meetings across the whole of South of Tyne made certain that planning was comprehensive, and more importantly that communication was effective and consistent. In anticipation of a third wave and the approach of winter, escalation plans were formatted in a consistent approach across the North East SHA. The North East Escalation Plan (NEEP) identifies what precipitates any escalation, the action that would be taken and the communication structures. NEEP plans will now be used in a consistent approach throughout the year to deliver an effective response to any emergency situation or surge in activity.

The 'Bigger Picture' work undertaken in collaboration with the Foundation Trusts and South of Tyne and Wear PCT continues to drive a strategic overview of care requirements across the patch. It has a particular focus on population trends and future demands for NHS secondary care services whilst also looking at the care closer to home agenda and being more responsive to patient need.

The Trust continues to be a key member of the City of Sunderland's Local Strategic Partnership (LSP) which brings together the public, private, voluntary and community sectors to work together to achieve success, encourage improvement and tackle and overcome problems for the benefit of everyone living in Sunderland now and in the future.

The Sunderland Strategy is the key document through which partners in Sunderland collectively set out their vision and priorities for the city, of which the improvement of the health and wellbeing of people is a key element.

The Trust is an active member of the following city wide groups:

- Adult Partnership Board;
- Safeguarding Adults Partnership Board and associated sub committees;
- Children's Trust Board;
- Local Safeguarding Children's Board and associated sub committees;
- Healthy City Delivery Partnership;
- Corporate Consultation group; and
- Compact Delivery Group

> "The Sunderland Strategy is the key document which partners in Sunderland collectively set out their vision and priorities for the city."

Scott Elwell, Directorate Manager for Radiology and Chris Wood, Clinical Director for Ophthalmology, having reached the summit of Mt. Kilimanjaro as part of a twenty strong team from the City of Sunderland Partnership.

OFR: FINANCE

The Trust experienced a number of significant challenges during the year, particularly over the winter months. In the prior financial year it was recognised that there was a need to increase the bed capacity to meet the ever growing demand predominantly associated with demographic pressures. The time taken to physically build this capacity meant that during the 2009/10 financial year, the Trust faced a further winter with once again a significant increase in numbers of patients seen and yet no increase in capacity. The Trust managed this increase by looking at opportunities to improve discharge processes in collaboration with PCT and Local Authority colleagues.

The impact of the introduction of a new tariff for clinical contracts in 2009/10, based on Healthcare Resource Group (HRG) version 4 had a significant impact on the way clinical income was received. The new tariff was completely different from the previous version, with an extension in the number of coded procedures as well as the prices of those procedures, plus a change in the mechanism for charging for outpatients.

Within this environment, the Trust and commissioners agreed activity levels predominantly based on 2008/09 actual activity plus anticipated additional growth requirements to achieve the necessary targets. In addition, the Trust took on an expanded contract for the provision of ENT activity within Gateshead. Given the volatility of the tariff prices, the Trust and commissioners agreed a risk share on some of the more volatile elements of the contract, particularly around a new element of the contract for 2009/10, being outpatient procedures.

The year saw the full introduction of the International Financial Reporting Standards (IFRS). Predominantly this had the effect of requiring the Trust to account for the impact of untaken annual leave and a number of changes around accounting for capital transactions. The latter saw some volatility in the last quarter as late changes to the requirements resulted in an impact on the overall Income and Expenditure position. The major impact of accounting under IFRS is presentational, with a requirement to re-state the 2009/10 opening balance sheet in the new format.

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 £10.7m as at the 31st March 2010. The plan was based on no over performance in clinical activity and upon successful delivery of cost reduction measures of £7.2m

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

Looking Forward

Immediately after the submission of the Annual Plan for 2009/10, all Foundation Trusts were required to prepare 'Downside' planning assumptions for the subsequent three years 2010-13. Monitor required all Foundation Trusts to consider the impact of the economic climate on finances and activity under a range of scenarios. The Trust pulled together these plans and submitted them to Monitor at the end of September 2009. The Board of Governors and Board of Directors reviewed these plans ahead of submission.

Since that time, the Trust has undertaken a major exercise working with colleagues particularly across the South of Tyne community to assess and prepare for the impact of reduced funding through tariff prices and expectations around reduced volume highlighted through the Operating Framework for 2010/11. Plans have been developed to significantly reduce the cost base of the organisation in 2010/11, with further savings to be made in subsequent years.

For 2010/11, the full impact of the NHS standard contract will apply. This means that the potential financial penalties inherent within the contract will come into effect. This includes the impact of the 'Commissioning for Quality and Innovation' (CQUIN) payment scheme, where the Trust has agreed with commissioners a range of quality measures whereby delivery 'earns' the Trust additional funding up to 1.5% of baseline funding.

As a principle the Trust has therefore set budgets for 2010/11 based upon the underlying outturn position from 2009/10. The national tariff assumes a gross inflationary funding of 3.5% offset by an assumed level of 3.5% cash releasing efficiency. In reality therefore, tariff prices remain unchanged for 2010/11. The impact of this 'technical' cost improvement requirement plus the resource releasing plans from the PCTs means that the Trust will require a significant cost improvement plan of £14m to enable all pressures including pay awards to be fully funded.

This will be delivered with individual plans each having an Executive Board and Clinical Director lead, ultimately feeding into a new Finance sub-committee monitoring process. The Finance sub-committee will take over the role of the previous PESC committee with an expanded remit.

Overall the budget has been set at a surplus of £2m with a continued positive cash balance at the end of 2010/11.

Cost Improvement Programme Plans

Divisional Plans for cost improvements were agreed at the start of the 2009/10 financial year. Included in the Annual Plan was a target of £7.2m, although internal plans were set higher. Most Divisions delivered their targets with some over achieving and assisting those areas where slippage occurred. The overall achievement was £9.27m.

The Divisional Directors were responsible for the delivery of the targets and progress against plan was reported regularly to the Productivity Efficiency and Savings Committee (PESC) which is led by Non-Executive Directors.

Surplus

The Organisation achieved a surplus of £1.21m for the year.

The cash position was £17.15m at the year end against a target of £10.72m with no drawdown from the working capital facility.

Capital Funding and Prudential Borrowing Limit

The Trust had an allocated Prudential Borrowing Limit of £62.7m at the end of 2009/10. At the start of the year, the Trust had an outstanding balance on a previous loan of £6.18m. In year, the Trust received £24.5m of the agreed Foundation Trust Financing Facility (FTFF) loan. The total value of the approved loan is £28m, of which the balance will be received in 2010/11.

Capital investment in 2009/10 was funded from internally generated funds and the FTFF loan. Total capital investments included the new ward block development funded from the FTFF loan, the combined heat and power plant, (which will reduce expenditure on energy and our carbon footprint), a further 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 2009/10. CHS has maintained the Public Sector Policy regarding payment of creditors during the year.

The cash balances at the year end were £17.15m, in excess of the plan £10.72m predominantly due to the receipt of the FTFF loan ahead of incurring the cost of the new build scheme which had been delayed by approximately 6 weeks due to the impact of the severe winter.

Financial Risks 2010/11

The key financial risks facing the organisation relate 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. Unfortunately the planned roll-out of Service Line Reporting (SLR) during 2009/10 into individual service lines was not able to be completed due to a number of technical system difficulties. High level SLR information was provided to support the move to SLR based budgets for 2010/11. As a consequence the envisaged benefits are not yet in place, although the principles of SLR have supported delivery of the Trauma and Orthopaedics CIP project in 2009/10. These issues will be resolved in early 2010/11 to support the cost improvement plans for the year. The Trust has rolled out Service Line Management to a limited number of Service Lines and this is intended to support increased quality and effective management of services.

A major element of the CIP plans is based on reduced demand assumptions and therefore cost reductions resulting from the ability of the Trust to reduce capacity. There are risks should demand not reduce in the way envisaged by the PCT as the costs associated with re-investment in capacity to manage unexpected demand could be greater than those savings released as part of the plan. In addition, as part of the 2010/11 Operating Framework, the price for emergency activity over and above that delivered at the end of 2008/09 will now be paid to Trusts at 30% of the full tariff rate. This means that if activity continues to grow, it will be reimbursed at a significantly lower rate than the cost of delivering that activity.

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 2009/10 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 HSBC and the Office of the Post Master General only. The Foundation Trust's net operating costs are incurred largely under annual service agreements 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 PBR. This means that in periods of significant variance against contracts there can be a substantial cash-flow impact. To alleviate this issue the NHS Foundation Trust has maintained an £18m working capital facility with its current Bankers, which was not utilized in 2009/10.

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 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 NHS Foundation Trust

County Durham & Darlington NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

North East Ambulance Services NHS Trust

National Blood Authority

Prescription Pricing Authority

NHS Litigation Authority

In addition other related transactions have been with some Government Departments and material transactions received via the University of Newcastle in relation to the funding of medical education.

Financial Performance

For the financial year 2009/10 key headline financial indicators are as follows:

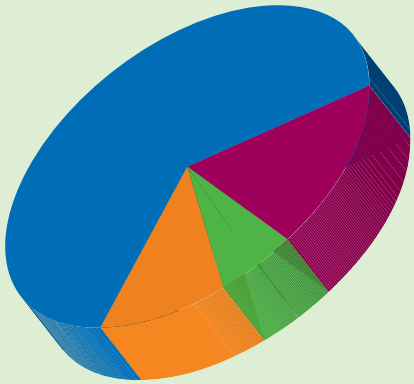
- The year ended with a surplus of £1.22m;
- The year ended with cash balances of £17.15m with no draw down on the working capital facility;
- Capital investment of £22.7m
- Private Patient Income of £295k or 0.11% of turnover (well within our formal cap).

Financial Headlines

2009/10	£ Million
Operating Income	285.64
Operating Expenditure	278.45
Dividends paid	5.50
Surplus	1.22
Capital Expenditure	22.7
Total Fixed Assets	190.89

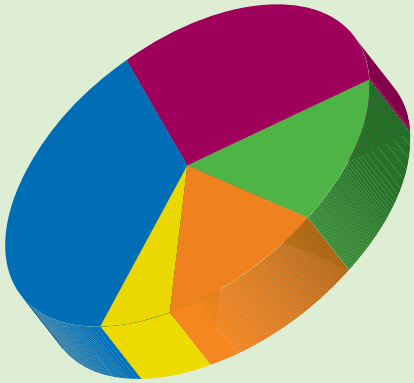
Income totalled £285.64m, a breakdown of the key sources is shown overleaf:

Income Analysis in 2009/10
(2008/09 figures in brackets)



- South of Tyne PCTs 68% (67%)
- Durham PCTs 16% (16%)
- Other Income from activities 6% (6%)
- General Income 10% (11%)

Staff Costs 2009/10
(2008/09 figures in brackets)



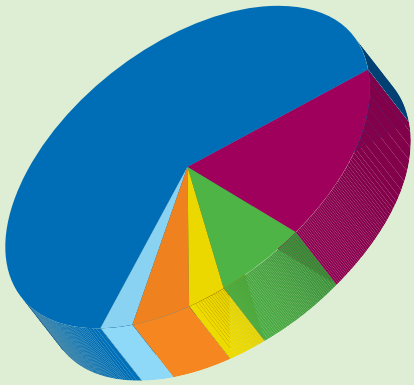
- Nursing & Midwifery 37% (36.7%)
- Medical & Dental 29.4% (29.8%)
- Scientific, Therapeutic & Technical 14.4% (14.2%)
- Administration & Clerical 13.1% (13%)
- Other 6.1% (6.3%)

Expenditure

Expenditure amounted to £278.45m. The majority of expenditure (65%) related to staff costs at £180.86m.

Full Details of Directors' Remuneration are included in the Annual Report on page 82.

Expenditure Analysis in 2009/10
(2008/09 figures in brackets)



- Staff Costs 65% (65%)
- Clinical Support Costs 17% (17%)
- Other 7% (6%)
- Premises 3% (4%)
- Services from Other NHS Organisations 5% (6%)
- Depreciation 3% (4%)

Planned Investment Activity

Capital expenditure in 2009/10 totalled £22.7m with significant investment in premises, medical equipment and information technology.

	£ Million
New Ward Block scheme	12.72
Premises (Inc. Backlog Maintenance & Demolition enabling)	3.26
Energy Project	2.44
IT Systems	0.80
Medical Equipment	0.62
Radiology equipment	0.56
Digital Theatres	0.54
Eliminating mixed sex accommodation	0.45
Pathology - removal of benches	0.35
Pharmacy Robot	0.19
Fire Alarms	0.18
Misc Spend – primarily equipment	0.59

The value of the Trusts fixed assets, both Tangible and Intangible, at the end of 2009/10 was £189.70m, plus non recurrent receivables, in total giving fixed assets of £190.89m.

It is anticipated that, in 2010/11, capital investment will be funded via internally generated resources plus the additional funding for the ward block extension (H Block) secured via the Foundation Trust Financing Facility.

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 as the Corporate Trustee for all "Funds Held on Trust" and is 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.

As at 31st March 2010, the pre-audit value of the funds held on trust amounted to £2.62m, an increase of £0.27m over the final 2008/09 position (£2.35m).

The value of income received amounted to £0.59m (£0.96m final 2008/09) and the value of resources expended amounted to £0.62m (£0.8m final 2008/09). Within this, £0.06m was spent on Research (£0.07m 2008/09). Capital purchases of equipment totalled £0.11m (£0.19m final 2008/09), for departments including Neonatology, General Surgery, Chemotherapy, Accident & Emergency, Rheumatology and Ophthalmology.

The Investment Portfolio at 31st March 2010 stood at £1.38m (£1.09m final position as at 31st March 2009), an increase of £0.29m. During the year the FTSE100 rose by 44% from 3926.14 to 5679.

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 2009/10

John Anderson QA CBE, Chairman

From 1 October 2008 for an initial period of three years

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 and Chairman of the Urban Regeneration Company Sunderland (ARC).

Committee Member: Board of Directors; Remuneration Committee; Productivity, Efficiency and Savings Committee.

Bryan Charlton, Non Executive Director

From February 1998. Re-appointed from June 2005 for three years which was extended by a further nine months until March 2009 and a further eighteen months until September 2010.

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.

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

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

From November 2002. Re-appointed from November 2006 for three years which was extended by a further year in November 2009.

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; Productivity, Efficiency and Savings Committee.

Mike Davison, Non Executive Director

From April 2007. Re-appointed from April 2009 until September 2010.

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; Corporate Governance Committee.

Miriam Harte, Non Executive Director

From September 2007 for two years. Re-appointed from September 2009 for a further two years.

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; Equality and Diversity Champion.

Roy Neville, Non Executive Director

From February 2005. Re-appointed in January 2009 until September 2011.

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, Chair of Parkside Community Centre and Chair of the Seaham Initiative, a regeneration project.

Committee Member: Board of Directors; Audit Committee; Productivity, Efficiency and Savings Committee; Control of Infection Champion, Counter Fraud Champion.

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.

Committee Member: Board of Directors; Remuneration Committee (for Executive Directors only); Productivity, Efficiency and Savings Committee.

Les Boobis, Medical Executive 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.

Committee Member: Board of Directors; Corporate Governance Committee.

Julia Pattison, Director of Finance, Divisional Director of Clinical Support

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; Corporate Governance Committee; Tendering Committee; Productivity, Efficiency and Savings Committee.

Carol Scholes, Director of Nursing and Quality, Divisional Director of Medicine

From July 1996

Mrs Scholes has worked in the NHS since 1974 and joined the Trust in July 1996 from the post of Director of Nursing at East Yorkshire NHS Hospitals Trust. Mrs Scholes is a School Governor of Yarm School.

Committee Member: Board of Directors; Corporate Governance Committee.

Mark Smith, Director of Strategy and Service Development, Divisional Director of Surgery

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; Corporate Governance 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.

Mr Bryan Charlton, Non Executive Director was initially appointed to the NHS Foundation Trust at its creation in July 2004 for the unexpired period of his term of office. Mr Charlton was re-appointed in June 2005 for a further three years. The Board of Governors extended Mr Charlton's appointment in March 2008 for a further year and then for a further eighteen months in January 2009 until September 2010.

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. 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.

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.

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.

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.

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 2009/10. As part of this process the Chairman had 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 Directors 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 Board 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.

Andrew Lansley, Secretary of State for Health with the Chairman and Chief Executive, when he visited the Trust in early 2010 (then Shadow Health Secretary).

Meetings of the Board of Directors

Board of Directors	Number of Meetings	Actual Attendance
John Anderson - Chairman	11	11
Ken Bremner - Chief Executive	11	11
Les Boobis - Medical Director	11	11
David Clifford - Non Executive Director	11	10
Bryan Charlton - Non Executive Director	11	11
Mike Davison - Non Executive Director	11	11
Miriam Harte - Non Executive Director	11	11
Roy Neville - Non Executive Director	11	10
Julia Pattison - Director of Finance	11	9
Carol Scholes[1] - Director of Nursing	11	8
Mark Smith - Director of Strategy & Service Development	11	11
Audit Committee	**Number of Meetings**	**Actual Attendance**
Roy Neville, Chair	5	5
David Clifford	5	4
Miriam Harte	5	5
Remuneration Committee	**Number of Meetings**	**Actual Attendance**
David Clifford, Chair	2	1
Bryan Charlton	2	2
Miriam Harte	2	2
Ken Bremner (for Executive Directors only)	2	2
Tendering Committee	**Number of Meetings**	**Actual Attendance**
Bryan Charlton, Chair	9	7
Mike Davison	9	8
Miriam Harte	9	6
Julia Pattison	9	8
Corporate Governance Committee	**Number of Meetings**	**Actual Attendance**
Julia Pattison, Chair	8	6
Carol Scholes[1]	8	4
Mark Smith	8	5
Mike Davison	8	7
Les Boobis[2]	8	2
Productivity, Efficiency and Savings Committee	**Number of Meetings**	**Actual Attendance**
Roy Neville, Chair	12	12
David Clifford	12	11
John Anderson	12	8
Ken Bremner	12	10
Julia Pattison	12	12

Note:

[1] Mrs Scholes has been on sick leave since December 2009

[2] Mr Boobis was only able to attend two meetings because of clinical commitments

Audit

Audit Committee

The Audit Committee has reviewed and commented upon the internal and external audit plans and the Local Counter Fraud plan. Internal Audit and Local Counter Fraud Service (LCFS) reports and updates have been reviewed by the Committee and progress on the implementation of any recommendations has been closely monitored.

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

Several members of the Audit Committee sit on the Productivity, Efficiency and Savings Committee which monitors the delivery of the Trust's cost improvement programme as well as overall financial performance.

The Committee has also received briefings with regard to preparations for the implementation of the International Financial Reporting Standards (IFRS).

The Audit Committee has reviewed the Statement on Internal Control and the Assurance Framework both of which are designed to mitigate risk in 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.

External Audit

During the year, the Trust purchased non audit services from the external auditors.

Non audit services purchased during 2009/10 included services circa £13,000 related to IFRS.

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

Remuneration Report

The Remuneration Committee for the Chief Executive and Executive Directors is chaired by the Chairman of the Trust. Other members include the Vice Chair of the Trust, a Non Executive Director and the Chief Executive. Membership of the Committee and attendance at the meetings is identified on page 74 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 i.e. 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 Hospitals' 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.

K W BREMNER

Chief Executive Date: 02 June 2010

Salary Entitlements of Senior Managers

	Age	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Golden Hello/ Compensation for loss of office
		£000	£000	£000
Mr K W Bremner[1] Chief Executive	49	(220-225)		
Mrs J Pattison Director of Finance	43	(130-135)		
Mrs C Scholes Director of Nursing	54	(120-125)		
Mr L H Boobis Medical Director	59	(100-105)	(110-115)	
Mr M Smith[2] Director of Strategy & Service Development	47	(40-45)		
Mr J N Anderson Chairman	64	(50-55)		
Mr B Charlton Non Executive Director	65	(15-20)		
Mr R N Neville Non Executive Director	70	(15-20)		
Mr D Clifford Non Executive Director	69	(15-20)		
Ms M Harte Non Executive Director	49	(10-15)		
Mr M Davison Non Executive Director	63	(10-15)		

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.

Notes:

[1] Mr Bremner received a one off (non pensionable) payment of £18k in 2009/10 which related to 2008/09. He also converted part of his car allowance to cash during the year.

[2] Mr Smith joined the Trust in December 2008 on secondment from the Strategic Health Authority. He was appointed to the substantive post on 1st December 2009.

Pension Entitlements of Senior Managers – 2009/2010

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 2010	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	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	35.0 - 37.5	295 - 300	1,423	1,093	275	0
Mrs J Pattison Director of Finance	40.0 - 42.5	125 - 130	491	302	174	0
Mrs C S Scholes Director of Nursing	12.5 - 15.0	210 - 215	1,158	868	247	0
Mr L H Boobis Medical Director	40.0 – 42.5	355 – 360	2,278	1,846	339	0
Mr M Smith[1] Director of Strategy & Service Development	0.0 – 2.5	115 – 120	534	478	32	0

[1] Mr Smith joined the Trust in December 2008 on secondment from the Strategic Health Authority. He was appointed to the substantive post on 1st December 2009.

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, 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.

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 2010 which comprise 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 Directors' 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 opinion, 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 Directors' Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements and the Directors' Remuneration Report of the NHS Foundation Trust for the year ended 31 March 2010 and complies with the relevant requirements of the directions issued by Monitor.

We have not considered the effects of any events between the date on which we signed ourreport on the statutory financial statements (7th June 2010) and the date of this statement.

PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
89 Sandyford Road
Newcastle upon Tyne
NE1 8HW

20th August 2010

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.

The auditors report on the full annual financial statements contained no statement on any of the matters on which they are required, by the Audit Code for NHS Foundation Trusts, to report by exception.

Board of Governors 2009/10

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 to be Lead Governor.

Patients Constituency:

From 1 July 2007

Duncan Stephen

Vacanct Seat

Public Constituency – North East:

From 1 July 2007

Yvonne Johnson

Wendy Westmorland

Public Constituency – Sunderland:

From 1 July 2007

John Anderson

Wilfred Curry

Stephen Blenkinsop

Thomas Hobson

Barbara Blyth

Ian Tunnicliffe

Vacanct Seat

Staff Constituency – Clinical

From 1 July 2007

David McNicholas

Suzanne Cooper

Staff Constituency – Other:

From 1 July 2007

Mandy Bates

Mary Pollard

Staff Constituency – Medical & Dental:

From 1 July 2007

Anthony Cross

Appointed Governors – City of Sunderland:

From September 2009

Councillor Norma Wright
(Cabinet Member with Portfolio for Health & Social Care)

Sunderland Primary Care Trust:

From March 2008

David Barnes
(Non Executive Director)

Meetings of the Board of Governors

Governor	Constituencies	Meetings in Public	Actual Attendance
Duncan Stephen	Patient	5	5
Vacancy	Patient	-	-
John Anderson	Public – Sunderland	5	0
Stephen Blenkinsop	Public – Sunderland	5	5
Barbara Blyth	Public – Sunderland	5	2
Wilfred Curry	Public – Sunderland	5	5
Thomas Hobson	Public – Sunderland	5	5
Ian Tunnicliffe	Public – Sunderland	5	4
Vacancy	Public – Sunderland	-	-
Yvonne Johnson	Public – North East	5	3
Wendy Westmorland	Public – North East	5	3
Mandy Bates	Staff – Other	5	4
Suzanne Cooper	Staff – Clinical	5	5
Anthony Cross	Staff – Medical & Dental	5	3
Dave McNicholas	Staff – Clinical	5	5
Mary Pollard	Staff – Other	5	5
David Barnes	Appointed – South of Tyne & Wear PCT	5	3
Cllr Eric Timmins	Appointed – City of Sunderland	3	3
Cllr Norma Wright	Appointed – City of Sunderland	2	1
Vacancy	Durham PCT	-	-
John N Anderson	Chairman	5	4
Carol Harries	Trust Secretary	5	5
The following Directors have attended a number of Governor meetings:			
Ken Bremner	Chief Executive		5
Les Boobis	Director		1
Julia Pattison	Director		2
Carol Scholes	Director		1
Mark Smith	Director		2
Bryan Charlton	Non Executive Director		1
David Clifford	Non Executive Director		1
Mike Davison	Non Executive Director		1
Miriam Harte	Non Executive Director		2
Roy Neville	Non Executive Director		2

1. Cllr Timmins stood down from his cabinet portfolio position in Health and Adult Services during the summer of 2009.
2. Cllr Norma Wright was appointed as the new cabinet portfolio holder for Health and Adult Services in September 2009.

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.

Establishment of the Board of Governors

Elections for the Board of Governors were held in June 2007 when the existing terms of office came to an end. Five of our previous Governors stood for re-election.

All the public and patient constituency seats were filled in an uncontested election. Governors were elected for a three-year term of office from July 2007.

The staff constituency was a contested election and all seats were filled for a three-year term of office from July 2007.

Elections for all constituencies will be held during May and June 2010.

The appointed Governors were chosen to represent their organisations through agreement between the Trust and the nominating organisation also for a period of three years.

Details of the constituencies are given in the Membership section.

Governor Involvement

Key areas where the Board of Governors have been involved during 2009/10 have included:

- input into our Annual Plan;
- involvement in our Patient Environment Action Team inspections;
- the extension 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 the key recommendations coming from the Mid Staffordshire report;
- assuring themselves of the Trust's approach during the pandemic flu outbreak;
- contributing to the Trust's approach to Clinical 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 96;
- 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

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.

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 their 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:

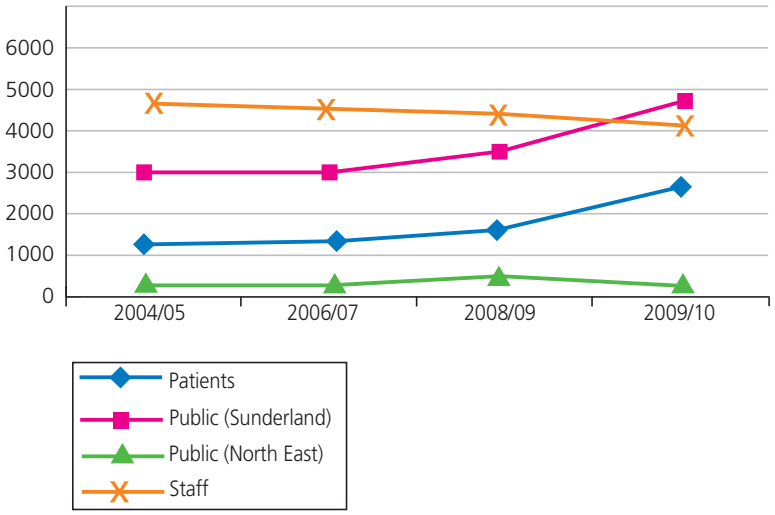
Constituency/ Class	Membership 2006/07	Membership 2007/08	Membership 2008/09	Membership 2009/10
Patients	1099	1091	1585	2810
Public (Sunderland)1	3042	3058	3502	4778
Public (North East)2	329	346	545	310
Staff -				
• Medical & Dental	355	343	321	300
• Clinical	1874	1820	1714	1946
• Other	2397	2220	2101	2223
Total	9096	8878	9768	12367

Notes:

[1] residents of the electoral wards of Sunderland Council

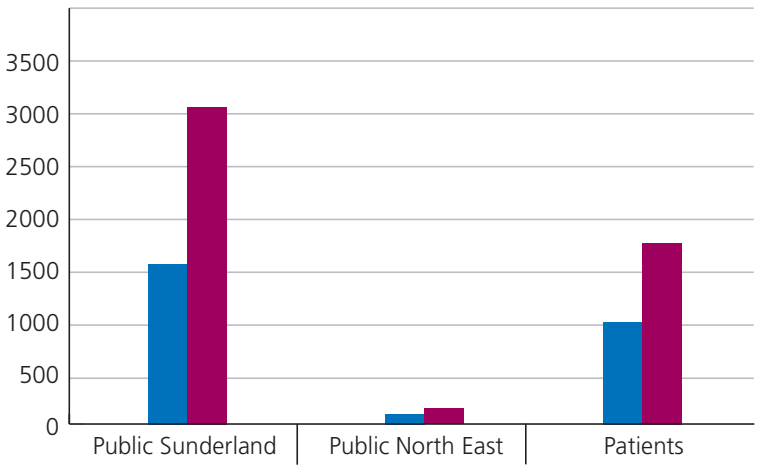
[2] residents of the electoral wards of the North East of England

Membership Growth



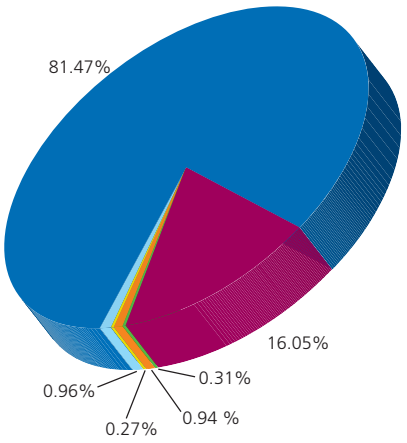
Public Membership

The following information illustrates the composition of the 4778 public Sunderland members, the 310 public North East members and the 2819 patient members as at 31 March 2010.



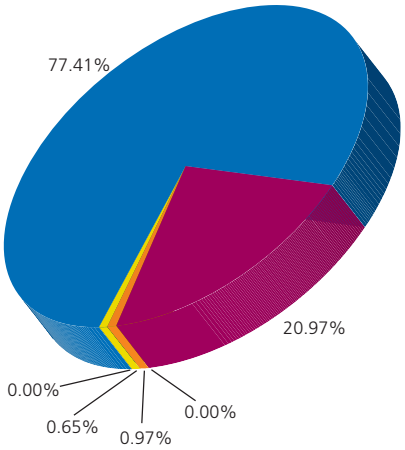
	Public Sunderland	Public North East	Patients
Male	1645	141	1035
Female	3133	169	1775

Ethnicity - Sunderland



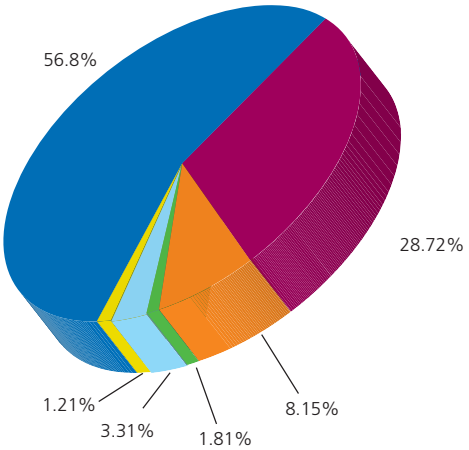
White 81.47%
Not specified 16.05%
Black/Black British 0.31%
Asian/Asian British 0.94%
Mixed 0.27%
Other 0.96%

Ethnicity - Public North East



White 77.41%
Not specified 20.97%
Black/Black British 0.00%
Asian/Asian British 0.97%
Mixed 0.65%
Other 0.00%

Ethnicity - Patients



White 56.8%
Not specified 28.72%
Black/Black British 1.81%
Asian/Asian British 8.15%
Mixed 1.21%
Other 3.31%

Age	Public Sunderland	Public North East	Patients
0 to 16 years	5	2	1
17 to 21 years	250	14	171
22 years +	4261	294	2601
Not stated	262	0	37
	4778	310	2810


PAEDIATRIC UNIT

Membership Strategy Summary

The Trust has an on-line membership database which has ensured that the database is routinely validated. 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 surpassed 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;

- Electronic membership form on the Trust website
- Membership forms located in GP surgeries, City Libraries, Age Concern and the Carers Centre
- A membership form is included with:
  - Clinical Governance patient surveys
  - "Your Stay in Hospital" booklet
- Active recruitment of members by our Governors

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 has now put in place mechanisms which will hopefully improve the situation.

The Trust is an active member of the city-wide Inclusive Communities group which again is developing much more meaningful systems of engagement. Whilst we continue to attract a relatively small number of new members from BME groups we do recognise that we need to do more work to attract a wider membership.

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 accessing the Corporate Affairs inbox address **Corporate.Affairs@chs.northy.nhs.uk**
- by writing to Governors at the following freepost address: **City Hospitals Sunderland NHS Foundation Trust**

FREEPOST NAT 21669
Sunderland
SR4 7BR

Public Interest Disclosures

Consultation and Involvement

The Trust has established a Patient and Public Involvement Steering Group with Governor representation to provide an overarching framework and approach to involvement. One of the key areas of focus during the coming year will be 'real time' patient survey work to be undertaken across all wards and departments.

During 2009/10 the Local Improvement Network (LINk) gathered momentum and has worked closely with colleagues in the Trust to develop its approach to 'Enter and View' which is due to commence shortly. The LINk may, in certain circumstance, enter health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services. It is hoped that by working with the LINk we can improve the standard of care that is delivered. The Director of Corporate Affairs also attends the core group meeting of the LINk to respond to issues and highlight particular issues.

The Trust also continues to work closely with the Health and Wellbeing Review Committee of the City of Sunderland, attending all meetings and contributing to a recent review of scrutiny arrangements within the city.

The Trust will also alert the Health and Wellbeing Review Committee in advance of any significant press issues.

The Scrutiny Committee referred the proposed Integrated Care Pilot proposal to the Secretary of State requesting greater clarity as to what constituted a pilot scheme. The proposal was one of sixteen Integrated Care Organisations (ICO) pilot projects which would allow new models of working to be explored – in our case between City Hospitals and Church View Medical Practice. Following our request for advice from the Independent Reconfiguration Panel (IRP) the Secretary of State responded to the OSC stating that "the pilot programme was an opportunity to test innovative models for service delivery aimed at improving the quality of patient care. The Church View Medical Practice/City Hospitals pilot has undergone a rigorous and detailed selection process within the Department of Health and has also been investigated and approved by the NHS Co-Operation and Competition Panel. I concur with this".

Members of the public are welcome to attend Governor meetings held in public and indeed a small number are mailed papers in advance of any meeting.

The meetings are advertised in the local press and on the intranet. Directors and Governors are available at the end of every meeting to discuss issues or concerns.

Communication and consultation with employees has been previously detailed in background information.

> "It is hoped that by working with the LINk we can improve the standard of care that is delivered."

Other Public/Patient Involvement

Community Panel

The Community Panel continues to play a vital and visible part in the Trust's commitment to patient and public involvement. During 2009/10 their work has involved:

- Undertaking a series of observations and measurements from wards taking part in the 'Time to Care' project. This essentially looks to increase direct time to care and eliminate waste and inefficiency within the patient environment. The Panel revisited the original four flagship wards to evaluate progress against the baseline data, and also collected further data for wards which joined the programme on a rolling basis.
- For the 6th year running the Panel helping with the Patient Environment Action Team (PEAT) inspection and provided an important impartial view to the process.
- One of the Panel members being involved in the National Institute of Heath Research (NIHR) Programme: improving patient safety through the involvement of patients working with the Institute of Health and Society at Newcastle University.
- Completing a Pharmacy Outpatient Satisfaction Survey which involved asking 100 patients about their views of the service, and in particular about their experience of waiting time.
- Revisiting the uniform recognition survey and undertaking a repeat survey to see whether recognition of the matron role among patients, families and visitors has increased. A presentation of the outcomes of the work will be given at the annual Standards of Care event in June 2010.
- Assisting the review of important Trust policies, which include the use of restraint in clinical care and a revision of the chaperone policy following new national guidance / best practice in this area.
- Ongoing, active contributions to a number of Trust working groups and committees, for example, the Sunderland Patient Involvement Group, Essence of Care Environment Group, Multidisciplinary Trauma Group, Nutrition Group and the Patient & Public Involvement Steering Group. Panel members add an important lay voice to these groups.
- Giving a presentation at the annual Therapy Services Best Practice Day on the topic of Patient & Public Involvement and the role of the Community Panel.

Equality & Diversity

The Trust has continued to drive forward its work during 2009/10 to ensure that it meets its duties as outlined in the Race Relations (Amendment) Act, Disability Discrimination Act, Single Equality Act and Human Rights Act.

Our key priority is to ensure that Equality and Human Rights are embedded into everyday practice so that we may achieve high quality health care for all. Our approach to meeting and monitoring our commitment to equality and diversity, and compliance with the equality legislation is incorporated into our Single Equality Scheme agreed by the Board of Directors in May 2008.

The implementation and monitoring of the Single Equality Scheme is governed by an Equality and Diversity Steering Group which is chaired by a Director, and supported by a Non Executive Director of the Board of Directors.

The Single Equality Scheme as legally required, is easily accessible on the internet and is accompanied by examples of Equality Impact Assessment (EIA) reports, which have driven changes and developments from the community groups we have worked with during the year.

The process of Impact Assessment aims to identify and eradicate potential areas of discrimination. Specifically work has been undertaken to look at the services offered by our PALS and complaints department, as local advocacy groups for people with learning disabilities had highlighted some concerns.

The Trust has also worked with the local Black and Minority Ethnic community to look at access to health services. The EIA identified some concerns and an appropriate action plan was developed to benefit marginalised groups in the community.

A further key area of work undertaken during 2009/10 was to review the report of the Healthcare Ombudsman into the Six Lives report by Mencap regarding the deaths of six patients with a Learning Disability. A Healthcare for All sub group feeds into the Equality and Diversity Steering Group to specifically address the needs of people with Learning Disabilities who access healthcare at our hospitals.

Working in partnership with Northumberland Tyne and Wear Mental Health Trust we now have a health transition nurse for patients with a learning disability working in the Trust supporting the specialist paediatric and adult teams in transition.

Our work/life experience scheme for students with profound physical and learning disabilities continues to develop and is now supported by a full time co-ordinator funded by the Strategic Health Authority. The scheme is now established in five further organisations across the North East with a waiting list of other organisations wanting to join.

The Trust is a significant employer within the local community and aims to create and maintain a truly diverse and representative workforce. Through our work on raising awareness of cultural diversity, as well as tackling racism, violence, bullying and harassment through a zero tolerance approach, we continue to try to create an environment which maximises the impact and effectiveness of all our staff.

As a Trust we are committed to working with the relevant agencies within Sunderland to assist carers, people with disabilities and those who are unemployed to develop the necessary skills to enable them to secure employment with us.

It is our policy that people with disabilities should have full and fair consideration for all vacancies. During the year, we continued to use the Government's "two ticks" disability symbol to demonstrate our commitment to interviewing those people with disabilities who fulfil the minimum criteria, and endeavouring to return employees to the workforce if they become disabled during employment. We will endeavour to adjust their workplace environment wherever possible to allow them to maximise their potential.

Details of our workforce statistics are shown overleaf:

Workforce Statistics

Ethnic Origin			
	FTE	Headcount	Headcount %
White	3885.38	4407	88.23
Mixed	27.18	28	0.56
Asian or Asian British	403.42	410	8.21
Black or Black British	60.04	62	1.24
Other (including undefined/not stated)	79.99	88	1.76
TOTAL	4456.01	4995	100.00
Age Profile			
	FTE	Headcount	Headcount %
16 - 20	50.71	54	1.08
21 - 25	425.73	446	8.93
26 – 30	481.18	525	10.51
31 – 35	532.92	591	11.83
36 – 40	629.86	709	14.19
41 – 45	659.97	741	14.84
46 – 50	656.76	722	14.45
51 – 55	581.64	656	13.13
56 – 60	311.71	374	7.50
61 – 65	116.07	162	3.24
66 – 70	9.46	15	0.30
TOTAL	4,456.01	4995	100.00
Gender			
	FTE	Headcount	Headcount %
Female	3,419.43	3,916	78.40
Male	1,036.58	1,079	21.60
TOTAL	4,456.01	4,995	100.00
Disability			
	FTE	Headcount	Headcount %
No	2.50	3	0.06
Not Declared	1.60	2	0.04
Undefined	4,430.42	4,965	99.40
Yes	21.49	25	0.50
TOTAL	4,456.01	4,995	100.00

The Chairman, John Anderson presenting an award to a student who had been on the work/life experience scheme for students with profound physical and learning disabilities.

Occupational Health

The Occupational Health team successfully led the seasonal and swine flu influenza campaign. A total of 2113 staff were administered the seasonal flu vaccine which represented a 34% increase on last year's figures. In addition 2023 swine flu vaccines were given to mainly front line staff in line with national guidance. The Trust was ranked at a 48.5% uptake for swine flu, the highest figure being 84.7% and the lowest 19.8%.

The team has also worked hard this year to build on the previous year's success in working with managers to reduce sickness absence. In 2009/10 it was 4.8% compared to 5.2% for 2008/09 – a reduction of 0.4%. This is a significant improvement especially in light of a number of staff who were absent with both seasonal and swine flu.

A two year staff weight management initiative, "Why Weight to be Fit", has been developed within the Trust following successful funding from the Strategic Health Authority. The 8-week programme is targeted at staff with a BMI over 30 and includes specialist dietetic advice and exercise sessions. The results of the initiative will be evaluated at the end of the two year period to measure the overall impact on staff health and wellbeing.

> "Director of Nursing, Carol Scholes was one of the first staff to have her swine flu vaccination."

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 and trips; and
- the overall management of risk based on the Health and Safety Executive's "Successful Health and Safety Management" guidance document.

The Health and Safety Executive (HSE) visited the Trust in March 2010 to review progress regarding the Trust's approach to the management of stress. Initial feedback of our new stress risk assessment process was very supportive and consistent with the HSE's Risk Management Standards.

The HSE formal report is expected in May 2010 but work will continue to roll out the process across the organisation.

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.

The local Fire Authority have completed a full audit of our fire risk assessments for the main Sunderland Royal Hospital site which supports the findings of our own risk assessment.

We continue to see higher levels of compliance with fire training through dedicated sessions and fire drills. Disappointingly however, the number of false alarms has risen largely due to work being carried out by building contractors currently on site.

It is hoped that when the building work is completed we will be able to reduce the number of false alarms as wards are upgraded when they are vacated or moved into the new wing.

Security

Our multi-disciplinary security group continues to meet on a monthly basis to identify and reduce security risks. Colleagues from the National Counter Fraud Security Management Service along with the support of Northumbria Police have been key to improving safety across all sites.

Our team of sixteen security officers provide 24/7 cover and provide support, advice and assistance to both the public and staff. The team are frequently called upon to support staff in potentially aggressive or violent situations, and they are trained in both control and restraint techniques and conflict management. Our officers provide escort duties to staff and members of the public particularly out of hours and respond to all calls from wards to help with potentially difficult situations.

Car parking control remains one of our constant challenges and is not made any easier by the loss of spaces during the current build. The team are there however, to help those who have difficulty in parking but also to impose infringement penalties on those who repeatedly flout the traffic management policy.

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.

CHS adheres to the legally binding Kyoto protocol and the Climate Change Act 2008 alongside NHS and government 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 on building on the success of our new combined heat and power unit a whole life cycle cost basis and ensure appropriate behaviours are encouraged in individuals as well as across the whole 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 the 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 and 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. Trials for recycling plastics, aluminium cans and glass are all ongoing.

- 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.

Summary Performance of Waste and Energy

Area		Non-financial Data (applicable metric)	Non-financial Data (applicable metric)	Financial Data (£k)	Financial Data (£k)
		2008/09	2009/10	2008/09	2009/10
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	1934 tonnes	2023 tonnes	417,924	500,763
	Amount of re-graded waste	720 tonnes	765 tonnes	n/a	n/a
Finite Resources	Water	221880m³	236216m³	385,046	415,203
	Electricity	59391GJ	59409GJ	1,308,978	974,215
	Gas	213572GJ	190123GJ	1,481,468	918,909
	Oil	1609GJ	2933GJ	24,898	45,436

Commentary

- Waste – The Trust has a multi-disciplinary Waste Management Review Group that meets monthly to identify and reduce the risks associated with the various waste streams within the organisation. A comprehensive audit programme has also been implemented and duty of care visits to all waste contractors are carried out.

The total waste tonnage produced by the Trust has increased by 4.63% from 2008/09 to 2009/10. This however, is compared to an increase of 5.6% of business activity based on the Trust's turnover.

Contributing factors to the increasing cost of the disposal of waste included the in year rise in land fill tax and the additional cost of recycling, in particular compliance with waste electronic and electrical equipment regulations.

Recycling levels have increased by 6.4% in 2009/10 compared to the previous year.

- Water – Usage has risen due to an increase in business and patient throughput, increased building activity on site, and the promotion of the 'Clean Hands' initiative.
- Electricity – There has been a slight increase in the electricity used, but when compared to the increase in Trust business activity based on turnover, the rise is insignificant. The electricity cost however, has dropped due to the increase in the new combined heat and power plant capacity.
- Gas – The development of the Trust's new Energy Centre which comprises three low pressure hot water boilers and the Combined Heat and Power plant has had a major impact on efficiency and subsequent reduction in gas usage.

Targets for Carbon Reduction Strategy and Climate Change Plan

In line with the Climate Change Act 2008, the NHS is required to reduce its 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 2010);
- 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).

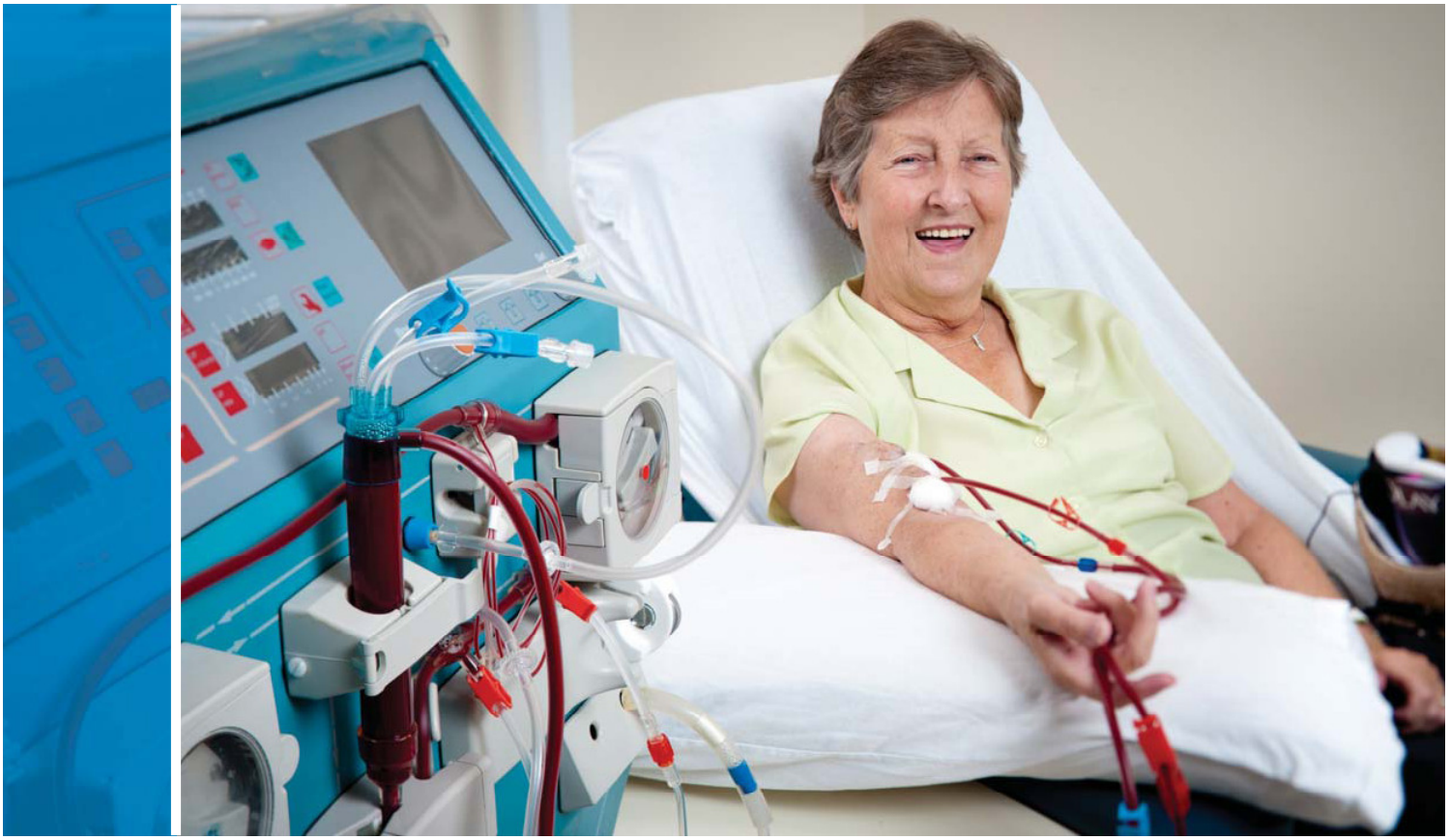
These targets will be incorporated into City Hospitals Sunderland's Carbon Reduction Strategy and Climate Change Plan and will be measured against the baseline data from 2007. Progress is being recorded against the achievement of the 2015 targets and will be regular reports made to the Board of Directors.

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".

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).



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 2010 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 4
- Chief Executive's statement on page 6
- Operating and Financial Review on pages 13 to 71
- Pubic Interest Disclosures on pages 95 to 104

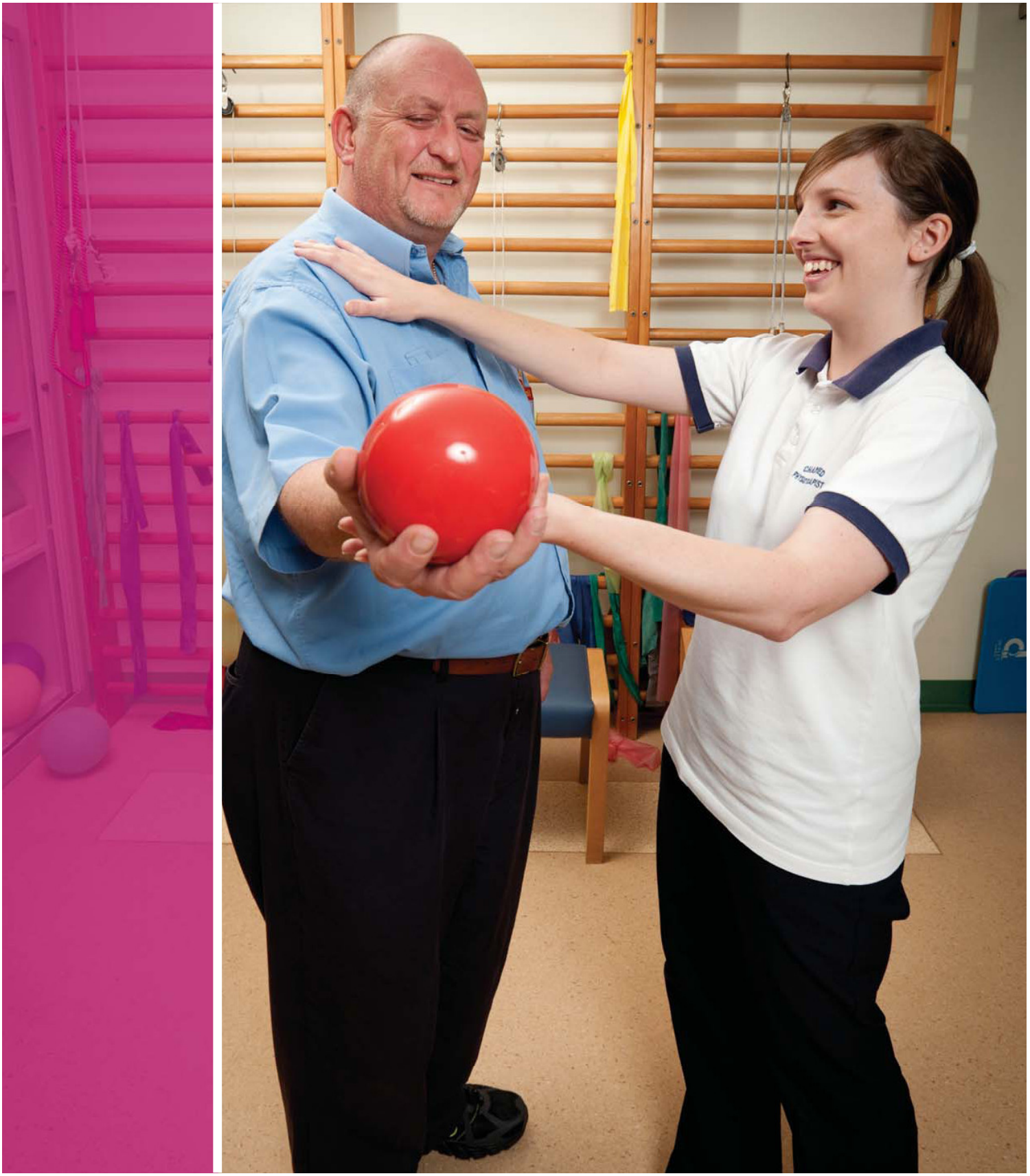
The Trust has complied with all relevant guidance relating to the better payment practice code, calculation of management costs and declaration of the number and average pension liabilities for individuals who have retired early on ill health grounds during the year. The relevant declarations are detailed in the Annual Accounts.

This section together with the sections of the Annual Report incorporated by reference consists of 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).

Audit Information

The Trust's external auditors have been PriceWaterhouseCoopers LLP for the financial year 2009/10 following their original appointment by the Board of Governors in 2006.

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.



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 Accounting Officers Memorandum issued by the Independent Regulator of 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 accruals 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 Financial 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: 02 June 2010

The laundry produces approximately 75,000 pieces each week.

Statement on Internal Control 2009/10

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 Sunderland NHS Foundation Trust for the year ended 31 March 2010 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 has increased the frequency of its meetings to ensure scrutiny, monitoring, discussion and input. The Finance reports to the Board have also been amended to ensure tracking of internal Cost Improvement Programmes. Finance Reports are presented in a format consistent with those submitted to Monitor. The Board receives appropriate, timely information and reports from the Clinical Governance Steering Group and Corporate Governance Committee enabling adequate and appropriate assessment of risk and management of performance.

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.

The framework covers the key business areas identified in the Trust's forward plan with the principal objectives divided into seven categories.

- Workforce, Education & Training
- Finance
- Clinical Governance
- Corporate Governance
- Access & Service Delivery and Development
- Performance
- Partnership

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 Board of Directors, and as such each of the key objectives has been assigned a Board lead. The Board uses the framework to ensure that the necessary planning and risk management processes are in place to deliver the forward plan for the next 3 years and 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 requirements of the 'Standards for Better Health' and other changes arising from the ongoing review of strategic risks.

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 Healthcare Commission, 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 and representative patient groups.

The risk to data security is being managed and controlled through the IM&T Strategy Board which produces an annual report including risk management assessments and is monitored through regular reporting to the Board of Directors. The Board of Directors sign off the Information Governance Toolkit which had an improved score for 2009/10.

The Foundation Trust is fully compliant with the core Standards for Better Health

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure that all employer obligations are complied with. This includes being satisfied 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. 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.

The Trust has strong governance arrangements in place which provide assurance that data used within the Quality Report is accurate and that the Trust follows specific national definitions when reporting. The Quality Report is a fair reflection on both areas of strong performance and areas where improvements can be made.

Although the Quality Report is produced annually the vast majority of information is routinely reported to the Board through various reports and committees which allows the scrutiny of such information on a regular basis.

6. 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.

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

- An Annual Corporate Service Plan, which sets out priorities for the coming business year and reflects the requirements of our major Commissioners.
- Performance management through regular reporting against the key deliverables set out in the Annual Plan 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 Productivity, Efficiency and Savings Committee.

The world wide recession has led us to re-evaluate our likely resources over the next few years and a great deal of planning has been undertaken to make sure that we deliver a safe patient experience with reducing resources. We have worked closely with our colleagues at the PCTs and SHA to confirm that our proposals are in line with the resources likely to be available.

During 2009/10 the Productivity, Efficiency and Savings Committee (PESC) was successful in overseeing the management team deliver a cost improvement programme of £9.2m. In addition to the scrutiny provided by PESC the cost improvement programmes were monitored on a monthly basis by the Corporate Management Team, chaired by myself as Chief Executive.

The work of the Service Line Management Board continued during 2009/10 with Obstetrics and Gynaecology followed by Ophthalmology being granted more autonomy as the first of the specialties to gain more independence. Financial Information was produced by Service Line during the year and presented to PESC on a quarterly basis. A Trust wide level of contribution per Service Line was set for the year and these details were used to construct 2010/11 budgets. Patient Level Costing information was further developed and is planned to be fully implemented next year.

The Executive Board, the Board of Directors and the 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 2009/10 the Trust has:

- Further developed the "Lean" process in the organisation and established this technique as the main tool with which to improve economy, efficiency and effectiveness of services as well as improving the experience, both for patients receiving and staff delivering.
- Followed last year's demographic review of population growth, with the commencement of construction of a four ward extension at the hospital. The review considered how the hospital could rationalise capacity on a single site and plans are currently in place to reduce capacity at satellite locations, bringing patients into a state of the art facility at Sunderland.
- Seen the introduction of our new Combined Heat and Power plant giving us the benefit of major savings on our energy costs as well as helping to reduce our carbon emissions as part of our Carbon Reduction Plan.

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.

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 and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and 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, the Corporate Governance Committee and the Clinical Governance Steering Group, 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 Board 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 Corporate Governance Committee and Clinical Governance Steering Group. The Corporate Governance Committee receives the minutes of the Clinical Governance Steering Group and coordinates the implementation of action plans through the Trust's risk register mechanism.

The data held within the Quality Report and the supporting actions are subject to regular review via the Executive Board, Board of Directors and the Clinical Governance Steering Group. Alongside these internal forums, further controls are in place with local commissioners where a number of the issues raised within the Quality Report are subject to review via Quality Review meetings and through the CQUIN framework. These forums and the supporting action plans ensure the Trust has a robust system of internal control over the key issues outlined in the report.

The Performance, Efficiency and Scrutiny Committee have been particularly effective in ensuring 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 City Hospitals Sunderland NHS Foundation Trust has a generally sound system of internal controls that support the achievement of its policies, aims and objectives.

K W BREMNER

Chief Executive Date: 02 June 2010

Summarised Financial Statements

The summarised financial statements are in IFRS format for the first time and in the full financial statements we are required to present comparatives for the Statement of Financial Position as at 1st April 2008. These comparatives are not shown in these summarised statements but are available in the full version.

(A full copy of the annual accounts is available upon request)

Statement of Comprehensive Income for the Year Ended 31 March 2010

	2009/10 Operating Position	2009/10 Exceptional Items	2009/10 Total	2008/09
	£000	£000	£000	£000
OPERATING INCOME	285,639		285,639	270,237
OPERATING EXPENSES	(278,452)	(2,853)*	(281,305)	(264,681)
OPERATING SURPLUS	**7,187**	**(2,853)**	**4,334**	**5,556**
FINANCE INCOME	84		84	840
FINANCE EXPENSES	(553)		(553)	(295)
PUBLIC DIVIDEND CAPITAL DIVIDENDS PAYABLE	(5,499)		(5,499)	(5,681)
NET FINANCE COSTS	**(5,968)**		**(5,968)**	**(5,136)**
CORPORATION TAX REFUND	0		0	15
SURPLUS / (DEFICIT) FOR THE YEAR	**1,219**	**(2,853)**	**(1,634)**	**435**
OTHER COMPREHENSIVE INCOME:				
REVALUATION AND IMPAIRMENT LOSSES	**(16,912)**		**(16,912)**	**(120)**
INCREASE IN THE DONATED ASSET RESERVE DUE TO RECEIPT OF DONATED ASSETS	**131**		**131**	**167**
REDUCTION IN THE DONATED ASSET RESERVE IN RESPECT OF DEPRECIATON	**(305)**		**(305)**	**(336)**
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR	**(15,867)**	**(2,853)**	**(18,720)**	**146**

*Interim Valuation carried out in year resulting in a price impairment.

Statement of Financial Position as at 31 March 2010

		31 March 2010	31 March 2009
		£000	£000
NON CURRENT ASSETS		**190,885**	**195,134**
CURRENT ASSETS	INVENTORIES	3,140	3,785
	TRADE AND OTHER RECEIVABLES	10,182	6,109
	TAX RECEIVABLE	0	15
	CASH AND CASH EQUIVALENTS	17,149	13,300
TOTAL CURRENT ASSETS		**30,471**	**23,209**
CURRENT LIABILITIES		**(23,163)**	**(26,753)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**198,193**	**191,590**
NON CURRENT LIABILITIES		**(33,029)**	**(7,706)**
TOTAL ASSETS EMPLOYED		**165,164**	**183,884**
FINANCED BY:	(TAXPAYERS' EQUITY)		
	PUBLIC DIVIDEND CAPITAL	99,158	99,158
	REVALUATION RESERVE	68,473	82,835
	DONATED ASSET RESERVE	1,684	1,965
	INCOME AND EXPENDITURE RESERVE	(4,151)	(74)
TOTAL TAXPAYERS' EQUITY		**165,164**	**183,884**

The financial statements were approved by the Board on 01 June 2010 and signed on its behalf by:

K W BREMNER
Chief Executive

Date: 02 June 2010

Statement of Changes in Taxpayers Equity

	TOTAL	PDC	REVALUATION RESERVE	DONATED ASSET RESERVE	INCOME & EXPENDITURE RESERVE
	£000	£000	£000	£000	£000
1 APRIL 2009	**183,884**	**99,158**	**82,835**	**1,965**	**(74)**
RETAINED SURPLUS FOR THE YEAR	(1,634)	0	0	0	(1,634)
REVALUATION LOSSES AND IMPAIRMENT LOSSES	(16,912)	0	(14,362)	(107)	(2,443)
INCREASE IN DONATED ASSET RESERVE DUE TO RECEIPT OF DONATED ASSETS	**131**	**0**	**0**	**131**	**0**
REDUCTION IN DONATED ASSET RESERVE IN RESPECT OF DEPRECIATION	(305)	0	0	(305)	0
31 MARCH 2010	**165,164**	**99,158**	**68,473**	**1,684**	**(4,151)**

Statement of Cashflows for the Year Ended 31 March 2010

	2009/10 £000	2008/09 £000
CASHFLOWS FROM OPERATING ACTIVITIES		
OPERATING SURPLUS FROM CONTINUING OPERATIONS	4,334	5,556
NON CASH INCOME AND EXPENSE:		
DEPRECIATION & AMORTISATION	7,136	7,239
IMPAIRMENTS	2,853	0
TRANSFER FROM DONATED ASSET RESERVE	(305)	(336)
(INCREASE) / DECREASE IN TRADE & OTHER RECEIVABLES	(3,674)	690
DECREASE / (INCREASE) IN INVENTORIES	645	(235)
DECREASE IN TRADE & OTHER PAYABLES	(556)	(5,559)
DECREASE IN PROVISIONS	(38)	(455)
TAX RECEIVED	15	0
NET CASH INFLOWS FROM OPERATING ACTIVITIES	10,410	6,900
NET CASH OUTFLOWS FROM INVESTING ACTIVIES	**(24,476)**	**(10,775)**
NET CASH OUTFLOWS BEFORE FINANCING	**(14,066)**	**(3,875)**
CASHFLOWS FROM FINANCING ACTIVITIES		
PUBLIC DIVIDEND CAPITAL RECEIVED	0	1,947
PUBLIC DIVIDEND CAPITAL REPAID	0	(1,695)
LOANS RECEIVED	24,510	0
LOANS REPAID	(430)	(430)
INTEREST RECEIVED	(256)	(276)
PDC DIVIDEND PAID	(6,040)	(5,681)
CASHFLOWS FROM OTHER FINANCING ACTIVITIES	131	167
NET CASH INFLOWS / (OUTFLOWS) FROM FINANCING ACTIVITIES	**17,915**	**(5,968)**
INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**3,849**	**(9,843)**
CASH AND CASH EQUIVALENTS AT 1 APRIL	**13,300**	**23,143**
CASH AND CASH EQUIVALENTS AT 31 MARCH	**17,149**	**13,300**

If you would like a full copy of the Annual Accounts, please contact;

Mrs C Harries
Director of Corporate Affairs
City Hospitals Sunderland NHS Foundation Trust
Trust Headquarters
Sunderland Royal Hospital
Kayll Road
Sunderland
SR4 7TP