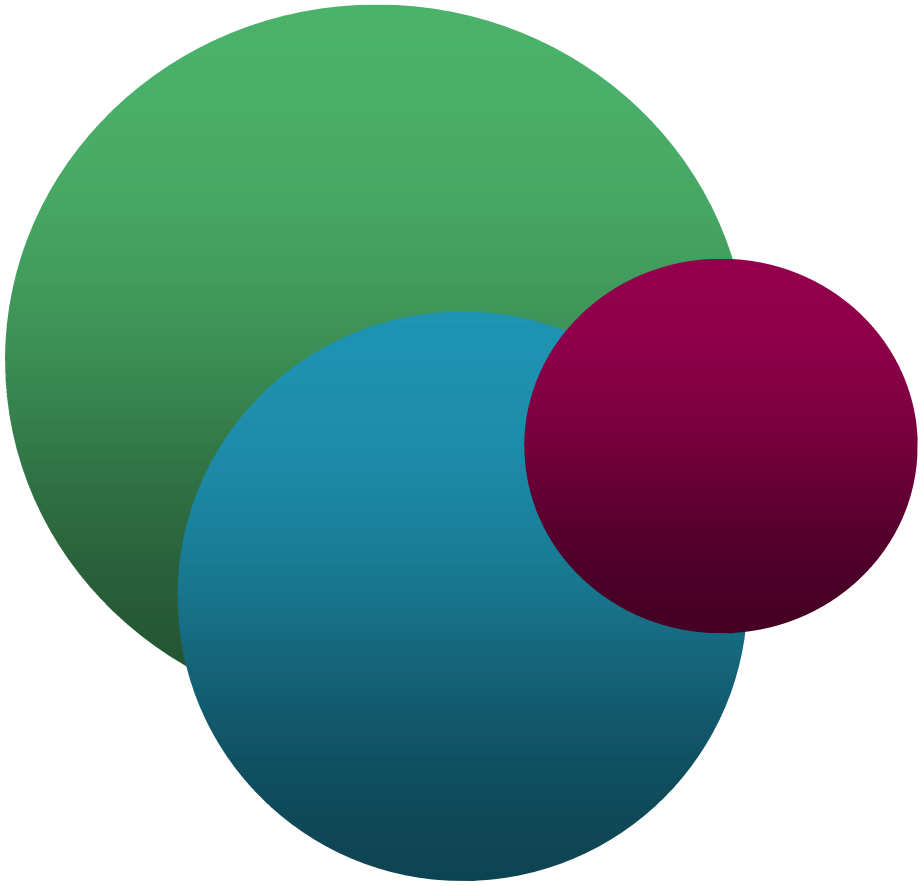
City Hospitals Sunderland chs

City Hospitals Sunderland NHS
NHS Foundation Trust

Quality Report 2012/13



Excellence in *Health*, putting *People* first

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A guide to the structure of this report

The Quality Report 2012/13 is an annual review of the quality of services provided by City Hospitals Sunderland NHS Foundation Trust during 2012/13. It is required by Government in an effort to strengthen and maintain the focus on quality of care for patients.

The Quality Report has a number of different sections;

- **Part 1** is a statement about what quality means to City Hospitals Sunderland, signed by the Chief Executive.
- **Part 2** highlights the Trust's performance in 2012/13 compared to the priorities that were agreed and published in last year's report. We have detailed how we performed against them and where we have only partially achieved objectives, and outlined our plans to ensure improvements are made in the future.

  Legislated statements of assurance from the Board of Directors complete this section.
- The key priorities for quality improvement in 2013/14 are highlighted in **Part 3**. We have explained how we decided upon our priorities and objectives and how we will achieve, and measure our performance against them. We have then provided other information that reviews our overall quality performance against key national priorities and standards.
- We have published (unedited) as **Annex One** the statements from our Commissioners, and the Overview and Scrutiny Committee in response to this Quality Report.
- The Statement of Directors' Responsibilities in respect of the Quality Report is published as **Annex Two**.

Every effort has been made to use clear and understandable language wherever possible during the production of the Quality Report. Given the nature of quality improvement in healthcare, the inclusion of some medical and healthcare terms is unavoidable. Further information about health conditions and treatments is available on the NHS Choices website, at www.nhs.uk.

About City Hospitals Sunderland NHS Foundation Trust

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

The Trust provides a wide range of Hospital services to a local community of around 350,000 residents along with an increasing range of more specialised services provided to patients outside this area, in some cases to a population as great as 860,000. The Trust also provides a substantial range of community based services, particularly within Family Care and Therapy Services.

The Trust operates from three main sites; Sunderland Royal Hospital, Sunderland Eye Infirmary and The Children's Centre, Durham Road (all owned by the Trust). The Trust provides outreach services at a range of local hospitals and health and care centres.

The Trust has an annual income of £309,549m and fixed assets of £204,88m. It employs 4,488.62 FTE staff or 5,051 headcount.

Part 1: Statement on Quality
from the Chief Executive

Welcome to our Quality Report for 2012/13. Once again our aim is to provide a balanced and honest account of how we did last year against the quality priorities we set ourselves. It also provides an opportunity to clearly set out what our plans are for the coming year.

In common with other NHS organisations, we have faced another challenging year in terms of needing to drive up quality and improvement but at the same time achieving efficiencies and savings in how we deliver our services. As the new structures align and interact in another reform of the NHS, we will also need to be in as strong a position as possible to continue to meet these demands for the benefit of the people who entrust us with their healthcare and support.

Against the background of the new context for healthcare, the publication of the recent Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry), provided a sobering and stark reminder of what can happen when the NHS gets its priorities wrong and loses its focus on patients, care and compassion. The Government has responded to the Francis Report in which it has said that quality of patient care should now be "at the heart of the NHS" when it's fair to say that most people using the health and care system thought this had always been the case.

City Hospitals has not been waiting for the Francis Report to give us our focus and direction on quality, standards and improvement. Quality in its many facets is already part of the strategic aims of the Trust and our organisational goals, objectives and relationships are driven by the various dimensions of quality, such as patient safety, clinical effectiveness and patient experience. Of course, we will fully embrace many of the recommendations from Francis to put patients, care and compassion at the very centre of what we do and how we do it.

The Quality Report is an annual public statement on our achievements in delivering quality and raising standards of care. I am pleased to report that we have met many of the goals and commitments that we set ourselves last year and are on track to meet many others. However, I will not shy away from reporting those areas where we didn't quite meet the challenge. I am confident that we are making progress, and I believe that today we are a cleaner, safer and kinder hospital than we have ever been, but I know we still have more to do.

Highlights of the year

We have embarked on a huge clinically-led change programme called 'Safe and Sustainable Emergency Care' to reform our whole emergency care pathways, including discharge and links with supportive services in Primary care. It has not gone unnoticed that our levels of emergency activity have been unprecedented this year, as it has elsewhere across much of the NHS. The time is right to undertake major reform of our emergency care system. This will involve a rebuild and modernisation of our current Accident & Emergency Department and acute care wards, including medical and surgical assessment areas. Our ambition is to provide an acute hospital fit for the 21st century and we look forward to that vision taking shape.

During the year we had a number of external, rigorous reviews of our quality governance arrangements, and I'm pleased to report that overall the Trust's arrangements were found to be well established and provided appropriate assurance in respect of quality performance and risk.

In November 2012 we had our annual unannounced visit from the Care Quality Commission. The inspection team spoke with patients and their visitors about their experience of Accident & Emergency, our Admissions Units and selected wards. We are delighted that they found no concerns about patient care or standards, and our staff demonstrated excellent practice in many areas.

We have achieved the majority of our Commissioning for Quality and Innovation (CQUIN)

targets in 2012/13, which is a significant success.

Our participation in national clinical audits goes from strength from strength and in the Sentinel Stroke Audit, our organisational score placed the Trust in the upper quartile for the first time and we were one of the highest performing Trusts in the North East.

During the year we also earned the prestigious CHKS Top 40 Hospital Award, recognising excellence in healthcare across key performance quality indicators. We also performed very well in the national Dr Foster 'Good Hospital' Guide 2012, including lower than expected or as expected ratings for different measures of mortality.

Our results in the NHS staff survey (2012) were also very positive, including an increase (for the third year running) in the percentage of staff who would recommend the Trust to their family and friends. We anticipate similar endorsement of our hospital from patients who answer the Friends and Family Test from April 2013.

Finally, we achieved national praise and profile of our Bariatric Services and the specialist skills and excellence in care we provide for this particular group of patients and their families.

Sharing our disappointments

Whilst the Quality Report rightly highlights where we have done well, it also reminds us on what areas we need to improve. This year, we have fallen short of our very challenging MRSA and C.*difficile* targets and were not able to continue our year on year reduction despite the significant effort from all our staff. We can report that there has been no evidence of any widespread failure in our preventative or control practices.

The publication of the annual adult inpatient survey (2012) also revealed that patients are still not always being offered a choice of food or feel that their pain is being adequately managed. In both these areas we made improvements last year and we thought we had 'turned a corner'. However, the results provide a further reminder that we still have much more to do.

The year ahead

There is no doubt that there are further challenging times ahead for the NHS and our Trust is not immune to the need to reduce costs and become more efficient in the way we provide our services. Our ambition will be to continue to drive and focus on improving quality whilst adapting to the changing nature of healthcare.

Our success and achievements over the past year can be attributed to the hard work of all our staff, volunteers, governors and other partners and stakeholders.

This Quality Report cannot cover all the work of such a large, complex organisation but I hope it provides an informative overview of where we have done well and those areas where we need to do better.

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

KEN BREMNER
Chief Executive **Date: May 2013**

Part 2A: Priorities for quality improvement

Quality Reports are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what we are doing well and where improvement is needed.

But, crucially, they also look forward, explaining what we have identified as our priorities for improvement over the coming financial year, and how we will achieve and measure them.

Review of Quality Performance 2012/13 – "Looking back"

Each year, we work with our staff, healthcare partners and local stakeholders to agree a number of priorities as part of our ongoing efforts to improve quality. These priorities provide our focus for quality improvement for the coming year, and we continually review progress that we are making.

The table below summarises the priorities and objectives we set for 2012/13; this is followed by a detailed account of our progress and achievements to date.

		Quality improvement objectives	
Clinical Effectiveness	**1.**	**Reduction in avoidable hospital acquired infection**	
		1a	MRSA bacteraemia
		1b	*Clostridium difficile* infection
		1c	MSSA bacteraemia
Patient Experience	**2.**	**Improvement of the patient experience and overall satisfaction in key areas**	
		2a	Increase food scores on quality, choice and assistance
		2b	Enhance the patients perception of pain management
Patient Safety	**3.**	**More effective management of the deteriorating patient to minimise avoidable harm**	
		3a	Improve staff recording, recognition and response to deteriorating Early Warning Scores (EWS)
Patient Safety	**4.**	**Reduction in the number of patient slips, trips and falls and their associated harm**	
		4a	To reduce the 'crude' number of patient slips, trips and falls
		4b	To reduce the number of incidents that result in major and catastrophic injury

Priority 1 — Reduction in avoidable hospital acquired infection

The reduction of avoidable healthcare associated infection has remained high priority for the Infection Prevention and Control Team throughout this year. A national point prevalence study on healthcare associated infection (HCAI) conducted in 2011 estimated that 6.4 % of hospital patients in England have a HCAI. These are infections that are neither present nor incubating (the period between infection and the onset of the disease) when a patient enters hospital. City Hospitals Sunderland strategy for 2012/13 included zero tolerance for preventable infection.

For 2012/13, the Trust was set the challenging targets of:

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

In addition we agreed to monitor the incidence of MSSA (Methicillin-resistant *Staphylococcus aureus*) bacteraemia, although there has been no national target set.

How did we do?

Indicator	07/08	08/09	09/10	10/11	11/12	12/13	Achieved / Not achieved
MRSA bacteraemia	37	33	20	8	4*	6	✗
Clostridium difficile	-	192	93	49	64*	60**	✗
MSSA	-	-	-	-	-	21***	N/A

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

* The cases represent all rates (both hospital and community acquired)

** 3 cases were moved following an appeal by the Trust and subsequent agreement by the Commissioners.

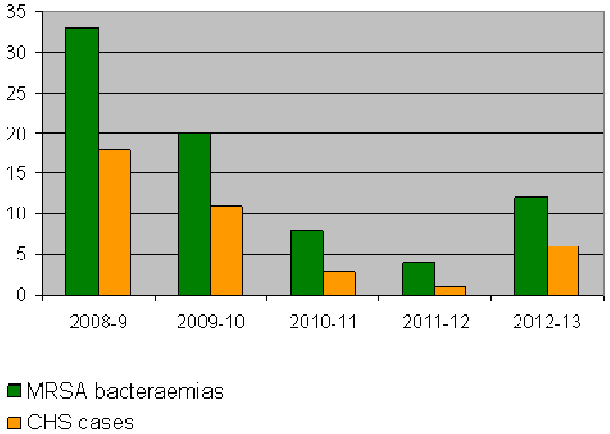
*** Hospital acquired cases in 2012/13

This year's target of 1 MRSA bacteraemia set by the Department of Health has proven a significant challenge to the organisation. We are disappointed that despite the increased efforts with hand hygiene, asepsis (protection against infection) and surveillance we were not able to continue our year on year reduction. We have reported 6 cases of healthcare associated bacteraemia this year and 6 community cases.

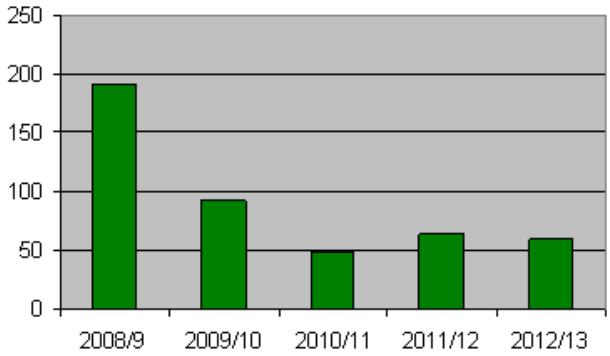
Detailed root cause analysis of each individual case of MRSA bacteraemia did not identify a single cause for the increase this year and there is no evidence of any systemic failure of control processes within the Trust. We are able to report that only 1 of the Trust apportioned cases was deemed avoidable. Lessons learnt from each case continue to be shared and have been incorporated into a detailed action plan which has been implemented and monitored throughout the year.

The target for *Clostridium difficile* infection was 44. This was a challenging target and there has been a huge drive, informed by the analysis of cases in 11/12 to further prevent, reduce and control this organism. Despite this, the number of cases reported for 2012/13 is 60. Whilst this is an improvement on the previous year's total it still causes concern within the organisation and maximum effort is being devoted to inform the strategy to reduce *clostridium* infection. No single cause has been identified for the failure to significantly reduce the number of cases and the Trust is taking very seriously actions required to address identified areas for improvement.

MRSA bacteraemia 2008 – 2013



Hospital acquired *C.difficile* infection



Achievements and initiatives during the year

- We have formed a *Clostridium difficile* multidisciplinary working party involving staff from areas where there has been Trust apportioned cases of *Clostridium difficile* to explore lessons learnt in detail and agree actions to prevent further cases,
- Deep dive exercises have been undertaken with members of the Trust's executive team to review and challenge current strategy for prevention and management of *Clostridium difficile*,
- The launch of the role of link staff/ ward managers to enhance compliance with antimicrobial (agents which kill micro-organisms) prescribing standards across in-patient areas,

- Daily stool and specimen surveillance to ensure prompt medical assessment and management of all patients with suspected infective diarrhoea,
- Circulation of a daily report across the organisation detailing any new cases of *Clostridium difficile*,
- Implementation of a targeted environmental screening programme in high risk areas, and additional cleaning of the hospital environment and equipment.

Other developments and activities throughout the year

- Monthly hand hygiene audits are now undertaken by peers replacing what was previously a self audit. This increases the objectivity and rigour of the audit process,
- A review of the Infection Control service provision has enabled on-site weekend cover during the period of winter bed pressures (Jan – March 2013),
- Completion of root cause analysis investigations for all Trust apportioned MSSA bacteraemia, identified to directorate action plans and dissemination of lessons learnt,
- Working in partnership with the community advisory panel to improve patient compliance with hand hygiene,
- The Infection Prevention and Control Team have established a robust system for continuous surgical site surveillance in trauma and orthopaedics,
- 120 staff participated in a one day Infection Prevention and Control study event held at the Sunderland Glass Centre,
- Continued close collaboration with clinical staff across all directorates to inform and deliver a robust strategy for management of outbreaks and serious infection.

Key areas for further improvement in 2013/14

- Plans to increase the availability of isolation facilities at Sunderland Royal Hospital,
- Review of Infection Prevention and Control education and training provision for hospital staff, patients and their carers,
- Development of a programme for enhanced deep cleaning of wards, which will include hydrogen peroxide fogging (a disinfection method used to eradicate or significantly reduce infection),
- Audit of decontamination of medical equipment,
- Screening programme for elderly care patients,
- Increased review and analysis of antimicrobial prescribing, to ensure there is not 'over-use' or misuse of antibiotics.

The infection Prevention and Control Team will continue to work closely with colleagues to reduce levels of healthcare associated infection throughout the Trust.

Priority 2 — 2a) Improvement of the patient experience: increase food scores on quality, choice and assistance

Last year the Trust focused on improving patients' rating and choice of hospital food. These areas had been categorised as 'red' in our annual national inpatient survey although there was some improvement in results reported last year. However in spite of these encouraging signs the Trust felt that these should remain one of our priorities.

Patient question	07	08	09	10	11*	12*
"Are you offered a good choice of food?"	79	77	75	83	8.1	7.7
"Did you get enough help from staff to eat your meals?"	71	68	68	73	7.7	6.7

Data source – national adult inpatient survey (Picker Institute)

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

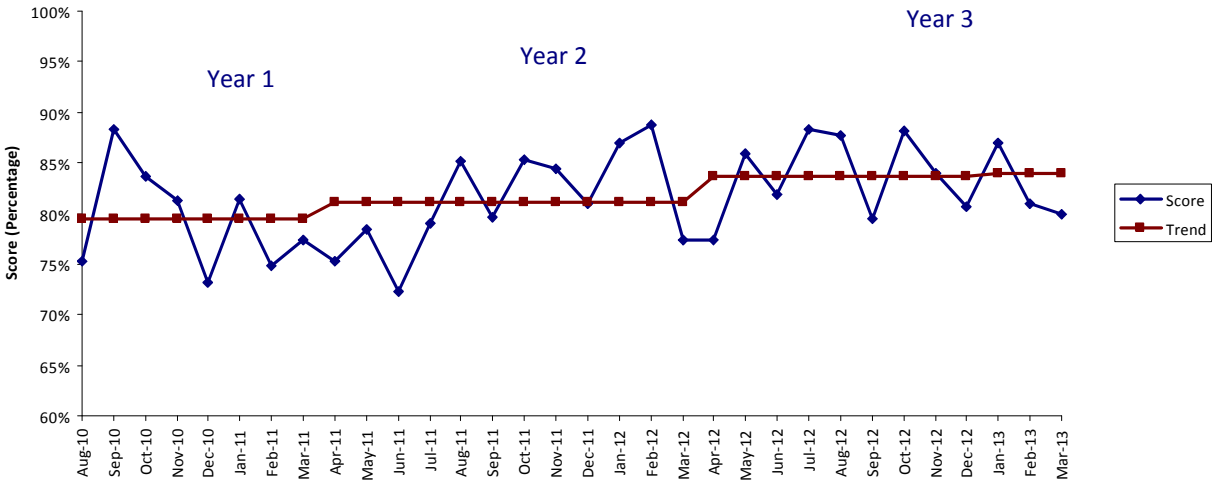
Unfortunately, the results from the national adult inpatient survey (2012) show that we have been unable to sustain our improvement from last year in this particular survey. However, the continuous monitoring of these questions in our real time feedback shows more encouraging results.

Real time feedback involves Trust volunteers asking a sample of patients who are ready for discharge for their views and comments about their hospital stay. This takes place on the majority of our wards each month and results are fedback to staff to enable them to make improvements in areas that matter to patients.

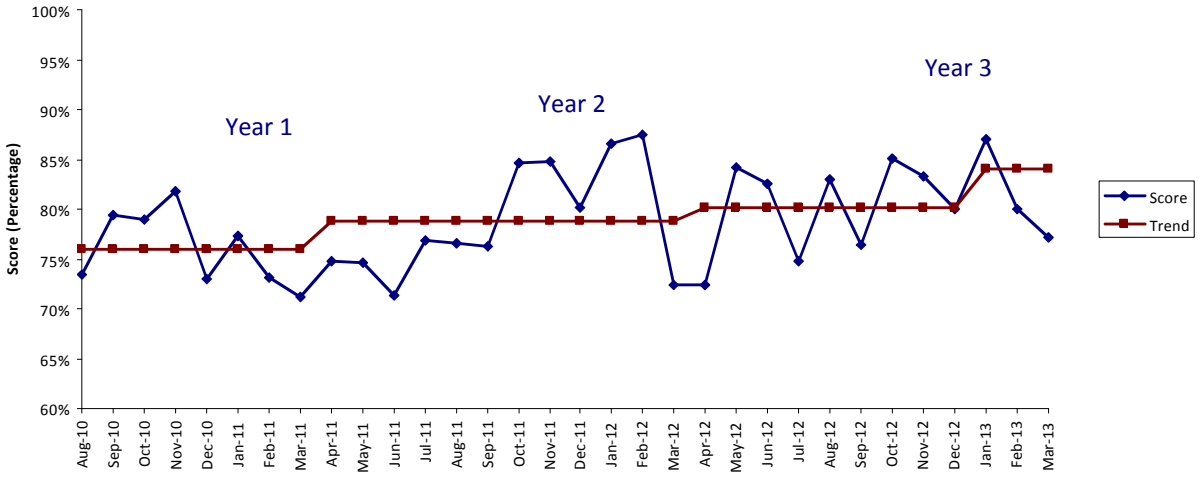
The charts below show results from real time feedback that asks three specific questions about patients' experience of hospital food. Each chart plots an average score from all participating wards for each month, starting from August 2010 to the end of March 2013. In addition there is a line showing the trend over time. For questions related to the presentation and temperature of food (Question C11) and choice of food (Question C12) we are able to see year on year improvement in scores.

Hospital food (real time feedback August 2010 – March 2013)

Question C11 – Food presentation and temperature (from real time feedback questionnaire)

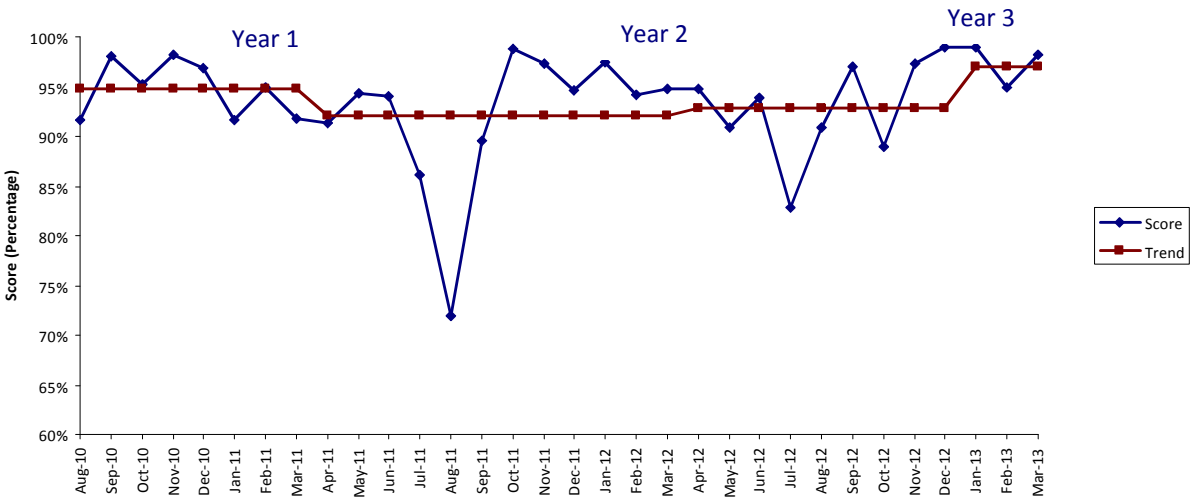


Question C12 – Choice of food (from real time feedback questionnaire)



However, the profile for giving patients assistance with their food (Question C13) shows more variation although the average scores are generally high with a 'spike' of improvement in the last quarter of 2012/13.

Question C13 – Help from staff regarding meals (from real time feedback questionnaire)



Other achievements or initiatives during the year

- Introduction of new **'Patient Menus'.** Each inpatient now has their own patient menu sheet. The menu also includes more prominent information about the 'Lite Bite Menu' and the availability of alternative menus,

- Improved the meal delivery service, for example by undertaking service time training with the catering staff and assisting nursing staff,
- Making available appropriate implements for the serving of food, for example tongs, insulated jugs to keep soup / custard at the correct temperature, and
- The Trust has made huge progress in the provision of locally sourced food, ensuring patients have a choice of meals and the feedback we are receiving is beginning to show that patients are enjoying the hospital meals that are offered.

Nutrition and Hydration Week – 'A Taste of Patient Safety' (18th – 24th March 2013)

A series of events to reinforce and focus energy, activity and engagement on nutrition and hydration as an important part of patient care.

To coincide with National Patient Safety Week – *A Taste of Patient Safety* - the Trust organised a number of Catering Department Tours to enable staff to see the food preparation for patients and learn more about the food that is provided in hospital. Staff then had the opportunity to sample hospital food.

Priority 2 — 2b) Improvement of the patient experience: enhance the patient's perception of pain management

While everyone has experience of pain it is often complex and poorly understood. It is subjective and can sometimes be challenging for patients and healthcare professionals to assess and manage effectively. Patients have reported in our national inpatient surveys that they feel that their pain management could have been better. We responded and set up a multidisciplinary Pain Management Group to look at ways to improve the patient's experience of pain. In the 2011 national inpatient survey we achieved our highest score for 5 years for the question *'do you feel staff did everything they could to mange your pain'* but we were still determined to do even better.

How did we do?

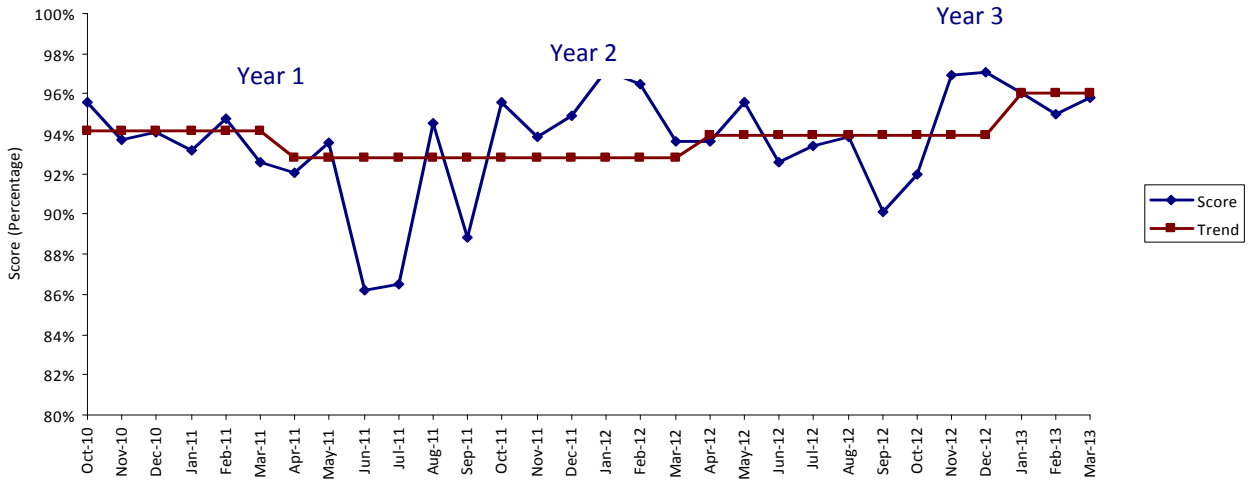
Indicator	07	08	09	10	11*	12*
"Do you feel staff do everything they can to manage your pain?"	80	79	80	79	8.1	7.5

Data source – National adult inpatient survey (2012)

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

The results of the national inpatient survey (2012) shows that we were not able to consolidate the improvement that we had made last year. This is disappointing given the significant work that has been undertaken in the Trust to improve pain assessment and management practices. However our real time feedback collection shows a more encouraging picture (see chart below) and we will continue to make pain one of our key clinical priorities.

Question C9 – How did staff manage patients' pain? (from real time feedback questionnaire)



Achievements or initiatives during the year

- The RADAR principles of pain management (**R**esponsibility, **A**nticipation, **D**iscussion, **A**ssessment and **R**esponse), is now being rolled out to wards within the Division of Surgery. This is an evidence based framework used by the clinical team to improve the effective management of acute pain,
- Development of specific analgesia Patient Group Directions (PGDs) for admission areas,
- An Acute Pain Study Day took place in March 2012, and
- Routine pharmacy reports for missed doses of medication are presented and discussed at each Pain Management Group meeting.

Priority 3 — More effective management of the deteriorating patient to minimise avoidable harm

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

How did we do?

Indicator	08	09	10	11	12
Early Warning Score (EWS) was recorded accurately	81%	91%	95%	94%	92%
Patients with a documented monitoring plan	*nm**	77%	93%	97%	94%
Patients had the minimum required frequency of observations / EWS in accordance with their level of care	*nm*	*nm*	*nm*	96%	94%
Monitoring plans were adhered to overnight	*nm*	79%	72%	83%	78%

Data source - CHS Level of Care / Early Warning Score Point Prevalence Study

* nm – not measured because it wasn't part of the survey at the time

Achievements or initiatives during the year

- The Critical Care Outreach Team (CCOT) continue to play a key role in improving the management of the deteriorating patient by :-
  - supporting the ward teams 24 hours a day, 7 days a week throughout the year, by offering a rapid response to wards when an early warning score trigger point is reached,
  - facilitating timely admissions to critical care and discharge back to the ward,
  - supporting the education and skills training of staff,
- A robust, rolling programme of acute and critical care education for all staff groups.
- The Deteriorating Patient Group (DPG) continue to analyse all reported deteriorating patient incidents, to identify any themes and trends and ensure lessons are learned,
- The DPG are leading on the implementation of the National Early Warning Score (NEWS) within the Trust. This will also involve a radical re-design of the observation / EWS chart and the current acutely ill patient pathway. Plans are to pilot this by the end of the year and to roll out across the Trust during 2013. A Trust Policy currently being developed will facilitate implementation,
- Continuation of monthly cycles of matron audits of observations and EWS scores, and
- EWS results are reported at Directorate Clinical Governance meetings and monitored by the Trust wide Deteriorating Patient Group (DPG). Remedial action is taken in any poorly performing areas and reported to Clinical Governance Steering Group.

Priority 4 — Reduction in the number of patient slips, trips and falls

Patients of all ages can fall in hospital but the rate is likely to be higher in the elderly, particularly when they are acutely unwell. Of particular concern are those falls where actual harm occurs, such as fractures, as these prolong hospital stay and may decrease the likelihood of a return to previous levels of independence. Patient falls are among the most common incidents reported in hospital and are a leading cause of death in people aged 65 or older.

During 2012/13 the national focus on patient falls has been enhanced with the mandatory collection of data on falls in hospital as part of the NHS Safety Thermometer. This is a survey tool that provides national benchmarking on key patient harms, which in addition to falls includes pressure sore, urinary tract infections and venous thromboembolism (VTE) or blood clots.

For 2012/13 the goal for the Trust was to reduce the number of falls among our in-patients and reduce the number of falls that result in moderate and major injury (*using definitions from the National Patient Safety Agency - NPSA*).

How did we do?

Indicator	08/09	09/10	10/11	11/12	12/13
Number of falls (including slips and trips)	Not available	1825	1636	1645	1720
Number of falls (with associated major and catastrophic injury*)	26	42	54	35	36

Source: City Hospitals '*Safeguard*' incident reporting system

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

Our falls prevention initiatives have failed to demonstrate any reduction in the number of falls this year although we did have some success in stabilising the position of those falls causing serious injury. The Trust multidisciplinary Falls Group has overseen a number of initiatives during the year to promote improvements in falls assessment and management practices.

- We have revised and updated the Trust Patient Falls Prevention Policy in line with national guidance and best practice,
- We have implemented a system of monthly monitoring of patient falls assessment documentation,
- Ward Sisters, Charge Nurses and Matrons are involved in regular quality assurance monitoring of falls prevention and management,
- We have raised awareness among staff to encourage the reporting of incidents to capture all slips, trips and falls data, and
- We have undertaken a pilot of non-slip slippers as a measure to prevent falls and introduced 'falling stars' which is a visual prompt to staff that a patient is at high risk of falling.

Forward Plan for 2013/14

- Reduce the number of patients sustaining a fracture of neck of femur or a head injury by 10%,
- Deliver harm free care by implementing the Royal College of Physicians Falls Safe Programme,
- Review the Trust's Bed Rail Policy in line with current best practice,
- Secure resources to assist in patient falls prevention,
- Learn lessons from incidents where patients have fallen, and
- Continue action on falls prevention and management overseen by the Hospital Based Falls Group and ensure engagement of key stakeholders.

Priorities for quality improvement 2013/14 – "Looking forward"

As in last year's Quality Report, we have grouped our priorities and plans under the three main quality headings; patient safety, clinical effectiveness and patient experience. In choosing our priorities, we have reviewed and reflected on our performance in 2012/13. This means that we will continue to focus on some areas that were identified last year, where we think more work can be done, as well as developing new themes from quality issues or feedback in 2012/13.

The review of quality performance during 2012/13 has taken account of the following areas;

- National planning and quality frameworks, i.e. NHS Outcomes Framework, Planning Framework (Everybody Counts), NHS Mandate, Commissioning for Quality and Innovation (CQUIN) scheme,
- National high level inquiries, i.e. Francis Inquiry (Mid Staffordshire NHS Foundation Trust),
- Feedback from external reviews of Trust services, for example from the Care Quality Commission, Monitor, the Primary Care Trust (PCT), and Local Involvement Network (LINk),
- Trust strategic objectives and service development plans,
- Patient safety issues from the Trust's incident reporting system,
- Patient, carer and public feedback on Trust services, including Real Time Feedback,
- Learning from complaints, the Patient Advice Liaison Service (PALS), incidents and quality reviews,
- Patient surveys and patient satisfaction questionnaires,
- Progress on last year's quality priorities and feedback on last year's Quality Report.

In setting our quality priorities for 2013/14, we have also involved, consulted and taken account of the views from senior managers (i.e. Corporate Management Team), a range of clinical professionals (i.e. Clinical Directorates and Clinical Governance Steering Group) and from patient and public representatives (i.e. Council of Governors).

Clinical Effectiveness

We will ensure that each patient receives the right care, according to best knowledge and practice, at the right time in the right place, with the best outcomes.

Priority 1: - Enhance the quality of life of patients with long term conditions - Improve the in-hospital management of patients with Dementia

Dementia is one of the most important issues we face as the population ages. There are currently approximately 820,000 people with dementia living in the UK, including 16,000 people under the age of 65. This figure is set to rise to approximately two million by 2033.

Up to 70% of acute hospital beds are occupied by older people, approximately 40% of whom have dementia. However, patients who have dementia experience many more complications and stay longer in hospital than those without dementia. It is also estimated that 30% of people will die with dementia and many of these die in general hospital settings.

Improving the quality of care in general hospitals has been identified as a priority within the National Dementia Strategy. The first round of the national audit of dementia care in general hospitals (2011) has found wide variation between participating hospitals on a range of standards. The report for City Hospitals

identified a number of areas for further improvement, some of which will be part of our priorities for 2013/14.

	Clinical effectiveness - Indicator	Measured by	Monitored by	Reported to
1	Patients assessed as 'at-risk' of dementia will have diagnostic assessments, investigations and appropriate follow-up	CQUIN internal data collection	Performance Team Dementia Group	Clinical Governance Steering Group
2	Reduce the number of falls and serious injury, particularly among those patients with dementia	Internal data collection	Performance Team Dementia Group	Clinical Governance Steering Group
3	Dementia patients are assessed on their risk of developing malnutrition and dehydration within 24 hours of admission (MUST score)	Meditech V6 Information system	Nutrition Steering Group	Clinical Governance Steering Group
4	Reduce length of stay of patients with dementia	Internal data collection	Performance Team Dementia Group	Clinical Governance Steering Group
5	Appropriate training of staff who care for patients with dementia	Internal data collection system	Dementia Group	Patient, Carer and Public Experience Committee
6	Ensure that carers of people with dementia feel supported	Carers Survey	Clinical Governance	Patient, Carer and Public Experience Committee

Patient Experience

We want all our patients to have a positive experience of healthcare. All our patients and the people who care for them are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Priority 2: - Ensure that we give compassionate care and people have a positive hospital experience

Compassionate care matters to patients. It is the presence or absence of compassion that often defines the lasting and vivid impression families have about their overall experience of care. It is a highly complex concept with different interpretations and one that is sometimes easier to identify when it is missing then when it is there. The recent report on the Mid Staffordshire NHS Foundation Trust ('Francis Inquiry') provided a sobering account on where compassion in care was missing in day to day contact with patients and their families.

Whilst the context for health care and support is changing, most significantly with people living longer with multiple and complex needs and higher expectations of healthcare, the need to retain compassion in care is more important than ever.

Whilst in general our patients are telling us that we get it right most of the time, there are occasions when our doctors, nurses, and other healthcare staff have failed to show compassion in their relationships with patients and their families. We know that compassion is central to how people perceive their care and how they describe their experience to others.

During 2013/14 we will focus on strengthening our approach to compassionate care and our relationships with patients and their families so that we improve their overall experience of City Hospitals. We will do this by focusing on the following indicators for improvement.

	Patient experience - Indicator	Measured by	Monitored by	Reported to
1	Improve the likelihood that patients would recommend our services to their family and friends	Friends & Family Test – 'net promoter score'	Patient, Carer and Public Experience Committee	Patient, Carer and Public Experience Committee
2	Increase the proportion of patients who feel listened to and involved in their care	National Inpatient Survey Real time feedback	Head of Nursing & Patient Experience Patient, Carer and Public Experience Committee	Patient, Carer and Public Experience Committee
3	Enhance the patients perception of pain management, i.e. reduce number of delayed / omitted analgesics	National Inpatient Survey Real time feedback	Pain Management Group	Patient, Carer and Public Experience Committee
4	Offer all patients a choice of food	National Inpatient Survey Real time feedback	Nutrition Steering Group	Patient, Carer and Public Experience Committee
5	Ensure patient feedback is acted on	Internal data collection	Matrons	Patient, Carer and Public Experience Committee
6	Improve end of life care through implementation of the 'Deciding Right' regional framework	CQUIN 2013/14 monitoring	End of Life Steering Group	Patient, Carer and Public Experience Committee
7	Training of staff in compassionate care	Internal data collection	Director of Nursing & Quality	Patient, Carer and Public Experience Committee

Patient Safety

The safety of patients is central to everything we want to achieve as a provider of healthcare. We are committed to improve the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by conducting thorough risk assessments of patients and investigating and analysing when things go wrong, identifying and sharing learning and making improvements to prevent or reduce the risk of a recurrence.

Priority 3: - Treating and caring for patients in a safe environment and promoting 'harm free' care

Patient safety is a priority at City Hospitals and our goal is to make our patients feel safe whilst they are in our care. Every member of our staff has a responsibility to;

- Care for our patients in a safe and clean environment,
- Perform their jobs competently,
- Use safe and effective techniques and technologies, and
- Ensure that patients are fully informed by providing them with information about their care and answering their questions.

Whilst safety is the responsibility of all staff, we also have a specific team dedicated to developing ways to enhance patient safety at all levels. The specific functions of this team are to work with frontline staff to implement projects to improve safety, measure when things go wrong and put actions in place to stop the same thing happening again and in addition to provide training on patient safety issues and best practice.

However, we recognise that sometimes things can go wrong during a hospital visit. We will continue to work to improve the safety of patients through the use of best practice, improved technology and

increased patient involvement. We will continue to engage fully in national safety campaigns, e.g. Patient Safety First Programme as well as learning from our participation in the NHS Safety Thermometer and its ambition to reduce key patients harms, such as pressure sores, patient falls, urinary tract infection and the risk of blood clots.

We have set out some specific areas of work for 2013/14 to promote safety and harm-free care across all our clinical environments, including wards, departments and outpatient clinics.

	Patient safety - Indicator	Measured by	Monitored by	Reported to
1	Reduce the number and severity of hospital acquired pressure sores	NHS Safety Thermometer	Patient Safety and Risk Management Team	Clinical Governance Steering Group
2	Reduce the number of drug administration errors	Internal incident reporting system Annual Diabetes Inpatient Audit	Diabetes Management Group Patient Safety and Risk Management Team	Clinical Governance Steering Group
3	Increase the number of 'near miss' incidents reported by staff	Internal incident reporting system	Patient Safety and Risk Management Team	Clinical Governance Steering Group
4	Improve staff recording, recognition and response to deteriorating Early Warning Scores (EWS)	Monthly audits Annual Point Prevalence Survey	Deteriorating Patient Group	Clinical Governance Steering Group
5	Reduce the number of serious patient falls	Internal incident reporting system	Falls Group	Clinical Governance Steering Group
6	Maintain the Trust's position of having a low rate of mortality	National SHMI* indicator CHKS – RAMI**	Clinical Governance Team	Clinical Governance Steering Group

* SHMI - Summary Hospital Mortality Index
** CHKS – RAMI – Risk Adjusted Mortality Index

Part 2B: Statements of Assurance from the Board

Statements of assurance from the board

Review of services

During 2012/13 City Hospitals Sunderland provided and/ or sub-contracted 40 relevant health services.

City Hospitals Sunderland has reviewed all the data available to them on the quality of care in 48% of these relevant health services.

The income generated by the relevant services reviewed in 2012/13 represents 51% of the total income generated from the provision of relevant health services by City Hospitals Sunderland for 2012/13.

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

- Local risk management arrangements, including Risk Registers, review of clinical incidents and risks to improving patient safety,
- Adherence to national and local infection control guidelines,
- Participation in national and local clinical audits and changes made to practice,
- Acting on the findings from complaints and patient surveys, including real time feedback,
- Evidence that national 'best practice' is being followed, i.e. implementation of NICE guidelines,
- Reviewing clinical outcome performance with peers and understanding the reasons for any variations in practice (using the CHKS benchmarking system).

Submission of a specialty Clinical Governance Review is in accord with a two-yearly cycle that is presented to the Clinical Governance Steering Group. This provide an important information review and assurance mechanism in summarising the overall clinical performance of our services, highlighting quality and safety issues and risks that need to be addressed, but also showcasing examples of good practice.

Accreditation schemes

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

- **Joint Advisory Group (JAG) on Gastro-Intestinal Endoscopy** – The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which Endoscopy is practised in the UK. The global rating scale (GRS) is the national framework for which an endoscopy unit is assessed in terms of quality. Sunderland went through its 5 year revalidation visit in December 2012. The outcome of this comprehensive and rigorous assessment was that our re-accreditation has been deferred for 6 months with a further inspection visit arranged for July 2013. This outcome is not uncommon. The majority of units across the country inspected will have their re-accreditation deferred pending completion of certain JAG recommendations. An action plan has been developed to ensure that the unit meets the JAG recommendations when reassessed.

Participation in Clinical Audit and the National Confidential Enquiries

The quality and safety of care is important to patients. They want to be assured that they receive care of the highest standard and that staff are professional and competent. Clinical audit is a powerful tool used to improve and assure the quality of patient care, by measuring and comparing current practice with known

best practice. That is why the Trust engages fully in the national clinical audit programme and supports its clinical staff in undertaking local audits of their practice.

During 2012/13, 39 national clinical audits and 4 national confidential enquiries which covered relevant health services that City Hospitals Sunderland provides.

During 2012/13 City Hospitals Sunderland participated in 87% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that City Hospitals was eligible to participate in during 2012/13 are as follows: (see table below)

The national clinical audits and national confidential enquiries that City Hospitals participated in during 2012/13 are as follows: (see table below)

The national clinical audits and national confidential enquiries that City Hospitals Sunderland participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits 2012/13

National Clinical Audits	Eligible	Participation	Comment
Older People			
Fractured neck of femur (College of Emergency Medicine)	✓	✓	Compliant with audit criteria. 50 cases submitted.
Carotid interventions audit (Royal College of Physicians)	✓	✓	Continuous data collection[1]
Hip fracture (National Hip Fracture Database)	✓	✓	Continuous data collection.
National Parkinson's audit (Parkinson's UK)[2]	✓	✘	No data submitted
Stroke national audit programme (SSNAP)	✓	✓	Organisational data submitted. Clinical data now continuous data collection.
National PROMs programme (NHS IC)	✓	✓	Continuous data collection.
National dementia audit (Royal College of Psychiatrists)	✓	✓	Compliant with audit criteria. Organisational audit and clinical audit involved 40 cases.
Women and Children's Health			
Paediatric pneumonia (BTS)	✓	✓	Submission ends March 2013. On target to complete
Paediatric asthma (BTS)	✓	✓	Compliant with audit criteria 39 cases submitted
Epilepsy 12 audit (RCHP)	✓	✓	Compliant with all audit criteria: Organisational audit, 30 cases submitted and patient experience questionnaire complete.
Paediatric intensive care (PICANeT)	N/A	N/A	
Neonatal intensive and special care (NNAP)	✓	✓	Continuous data collection.
Fever in children (College of Emergency Medicine)	✓	✓	Compliant with audit criteria. 50 cases submitted.
Heavy menstrual bleeding audit (RCOG)	✓	✓	Compliant with audit criteria

Acute Care			
National joint registry (National Joint Registry Centre)	✓	✓	Continuous data collection.
Adult critical care ICNARC	✓	✓	Continuous data collection.
Severe trauma (TARN)	✓	✓	Continuous data collection.
Renal colic	✓	✓	Compliant with study criteria. 50 cases.
Emergency use of oxygen (BTS) [3]	✓	✗	No data submitted
Adult community acquired pneumonia (BTS)	✓	✓	Compliant with audit criteria, data entry underway.
Adult non invasive ventilation (BTS)	✓	✓	Compliant with audit criteria, data entry underway.
Pleural procedures (BTS)	✓	✓	Compliant with audit criteria
Cancer			
National lung cancer audit (NHS IC)	✓	✓	Continuous data collection
Bowel cancer (NHS IC)	✓	✓	Continuous data collection
Head and neck cancer (NHS IC)	✓	✓	Continuous data collection
National oesophago-gastric cancer (The Royal College of Surgeons)	✓	✓	Continuous data collection
Long term conditions			
National paediatric diabetes audit (RCCHP)	✓	✓	Continuous data collection
National diabetes audit (Adults)	✓	✓	Continuous data collection
National pain audit	✓	✓	Compliant with audit criteria
Renal Registry (UK Renal Registry)	✓	✓	Continuous data collection
UK inflammatory bowel disease (RCP)	✓	✓	Compliant with 3 out of the 4 study elements
Bronchiectasis (BTS)[3]	✓	✗	No data submitted
Adult asthma (BTS)[3]	✓	✗	No data submitted
Heart			
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✓	✓	Continuous data collection
Coronary angioplasty (NICOR)	✓	✓	Continuous data collection
Paediatric cardiac surgery (NICOR Congenital heart surgery)	N/A	N/A	
National cardiac arrest audit	✓	✓	Continuous data collection
Adult cardiac surgery audit (CABG and valvular surgery)	N/A	N/A	
Acute myocardial infarction (MINAP)	✓	✓	Continuous data collection
Heart failure	✓	✓	Continuous data collection
Pulmonary hypertension (NHS IC)	N/A	N/A	
Cardiac rhythm management audit (NICOR)	✓	✓	Continuous data collection
Mental health			
Psychological therapies (Royal College of Psychiatrists)	N/A	N/A	
Prescribing observatory for mental health services (Royal College of Psychiatrists)	N/A	N/A	
National audit of schizophrenia (Royal College of Psychiatrists)	N/A	N/A	
Blood and transplant			
Cardiothoracic transplantation (Royal College of Surgeons)	N/A	N/A	
Renal transplantation (NHSBT UK Transplant Registry)	N/A	N/A	
Comparative audit of blood transfusion	✓	✓	Compliant with audit criteria.

			Organisational, rate of sample rejection, error follow up.
Potential donor audit (NHSBT UK))	N/A	N/A	No data submitted
Other			
National health promotion in hospitals audit (NHPHA Clinical Effectiveness Unit)4	✓	✘	No data submitted

1 The Trust is participating in the audit; data is collected on a continual basis rather than a sample of patients
2 Not able to participate this year because of limited time and resources
3 Not part of the Thoracic Medicine audit programme 2012/13
4 Did not participate this year and the audit is not part of the national programme in 2013/14

National Confidential Enquiries 2012/13

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

During 2012/13 City Hospitals was eligible to enter data into 4 NCEPOD studies. The tables below provide a summary of our participation.

Confidential Enquiry: **Subarchnoid haemorrhage (SAH)** - is a sudden leak of blood over the surface of the brain. The brain is covered by layers of membranes, one of which is called the arachnoid. An SAH occurs beneath this membrane.

Cases included	Cases excluded	Tertiary questionnaire returned*	Secondary questionnaire returned*	Case notes returned*	Sites participating	Organisational questionnaire returned*
6	1	0	6	6	1	0

Note - this study is still open and the figures have not been finalised

Confidential Enquiry: **Alcohol related liver disease** - is a range of conditions and associated symptoms that develop when the liver becomes damaged due to alcohol misuse.

Cases included	Clinical questionnaire returned*	Case notes returned*	Sites participating	Organisational questionnaire returned*
3	2	2	1	1

Confidential Enquiry: **Bariatric surgery** - promotes weight loss by changing the digestive system's anatomy, limiting the amount of food that can be eaten and digested.

6	6	6	1	1

Confidential Enquiry: **Cardiac arrest** - a condition in which the heart suddenly stops beating.

Cases included	Prospective forms returned	Questionnaires returned*	Case notes returned*	Sites participating	Organisational questionnaire returned*
8	8	8	8	2	2

* number of questionnaire / case note returns NCEPOD has accepted for included cases, including non returns with valid reasons

Our participation in other national confidential enquiries is highlighted below;

Enquiry title	Organisation	Participation	Status
Asthma deaths	National Review of Asthma Deaths (NRAD)	Yes - 100%	Complete
Child Health	MBBRACE – UK*	Yes - 100%	Continuous
Maternal infant and perinatal care	MBBRACE - UK	Yes - 100%	Continuous
Homicide and suicide	National Confidential Inquiry into Homicide and Suicide (**NCISH)**	Not applicable	

* Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK) is the new organisation for national confidential enquiries in maternal, perinatal and infant care

National clinical audits

The reports of 15 national clinical audits were reviewed by the Trust in 2012/13 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

The **National Diabetes Inpatient Audit** is the largest known audit of the care provided to hospital patients with diabetes. The results highlighted that we need to improve the review of patients by the diabetes and foot protection team, increase the level of patient involvement in their diabetes care planning and reduce drug prescription and insulin errors. Actions taken and new developments include;

- Working with the Regional Insulin Safety and Knowledge (RISK) group to develop a regional insulin prescription chart. This would ensure that insulin prescribing is standardised across the whole of the North East. The chart has several features designed to reduce the number of insulin prescribing errors. The chart also has sections for the management of hypo and hyperglycaemia (high blood sugar) , a discharge checklist and is also designed to be used in conjunction with the insulin passport,
- We are revising our Diabetic Ketoacidosis protocol (potentially life-threatening complication in patients with diabetes) and currently working on a hyperglycaemia protocol which will offer advice on the management of patients who are have naso-gastric feeding or total parenteral nutrition (artificial feeding),
- We continue to work with our colleagues in anaesthetics to update and improve our perioperative guidelines for diabetes patients who require surgery,
- The Diabetes Steering Group reviews all insulin prescribing errors and diabetes management errors. A revised proposal is being developed to feed back to each individual team the outcomes of these discussions and we will subsequently look at the steps the teams involved have taken to address any issues that led to the incident. This should allow us to “close the loop” and ensure that errors do not continue, and
- We have introduced the ‘insulin passport’ which is a patient-held record which documents the patient’s current insulin and enables a safety check for prescribing, dispensing and administration of insulin.

The **National Parkinson’s Audit** assesses the extent to which Parkinson’s disease practice matches up against published National Institute of Health and Care Excellence (NICE) Clinical Guidelines. In general, City Hospitals are above average in most areas identified in the audit but there are some areas that require action;

- We will improve the information being given to patients on the side effects of dopamine agonist drug therapy and review on follow up. This needs to be adequately documented, and
- With regard to improving the engagement with ethnic minority groups we will endeavour to meet local community leaders to highlight Parkinson’s disease and its symptoms and promote the service at City Hospitals.

The **National Heart Failure Audit** was established to monitor the care and treatment of patients admitted to hospital with heart failure. Heart failure is a serious condition caused by the heart failing to pump enough blood around the body at the right pressure. It usually occurs because the heart muscle has become too weak or stiff to work properly. The Trust has a Heart Failure Inpatient Service and we performed well in most areas of the audit, but we need to improve in some including;

- Reducing even further the 30 day readmission rates for patients discharged with Heart Failure, and
- Improving the collaboration with Cardiology to optimise inpatient management and follow-up in clinics and liaison services.

The **National Hip Fracture Database** was set up as a collaborative venture by the British Orthopaedic Association and the British Geriatrics Society to improve hip fracture care and secondary prevention. The

Trust performs well across a number of outcomes but the audit did highlight some improvements needed around the prevention of pressure sores and clinical staff needing to look at ways to minimise delays in patients going to theatre. Some of the identified improvements include;

- Reviewing theatre efficiency and utilisation to avoid delays in patients attending theatre,
- Provision of air mattresses as a preventative measure for pressure sores, and
- Reviewing pre-fracture bone protection prescribing.

Local clinical audit

The reports of 142 local clinical audits were reviewed by the provider in 2012/13 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided:

- An automated discharge checklist for completion for all paediatric patients admitted with wheeze or asthma regarding their ongoing asthma education (based on British Thoracic Society guidelines),
- An audit in Renal Services showed that peritoneal dialysis catheter placement was leading to early exit site infection. The Renal team have worked with their surgical colleagues and changed to 'buried' peritoneal dialysis catheters so that no exit site exists until just prior to using the catheter. This has reduced our early exit site infection rate,
- Orthopaedics undertook an audit of patient experience outcomes of the pre-operative hip school (which provides pre-operative information for patients who are being admitted for hip replacement). The findings were so positive that we have continued to provide this service and have now launched a pre-operative knee school,
- An audit looking at inappropriate readmission and length of stay in Parkinson's patients has resulted in several changes to practice, including routine contact with the Parkinson's Disease Nurse Specialist,
- Parkinson's medications are now kept as stock in emergency areas and appropriate ward areas to ensure quicker access. This helps to reduce the risk of mobility and disability problems caused by delayed or omitted medications,
- The Emergency Department has been working with the Renal Team to introduce a flowchart / protocol for the management of patients with acute kidney injury (rapid loss of kidney function), and
- Previous audits have shown that some antimicrobial drug doses are inappropriately omitted during drug administration round, i.e. non-availability and supply of drugs. This was addressed through nursing education and careful remodelling of the non-administration codes on our Trust electronic patient record, to improve professional accountability for these decisions. A re-audit has shown significant and sustained improvement in reducing missed drug doses. (*This particular audit also won the City Hospitals Sunderland Clinical Audit Award 2012*)

Participation in clinical research

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

- Increasing research activity and recruitment,
- Strengthening industry collaboration by increasing the number of commercial studies on the NIHR portfolio and maximising industry contribution,
- Efficient and effective set up and delivery of research studies, streamlining the approvals system, improving sign off times, recruitment to time and target, and improving integration of research into clinical care, and

- Maximising engagement, increasing the number of patients offered access to NIHR portfolio studies within each NHS Trust.

A strong research culture is embedded in the Trust with the Research and Development department forging key working partnerships with Clinical Directors, Directorate General Managers, HR, Finance, Information Governance, Pharmacy, Clinical Governance, Nursing and Quality and support departments. Effective liaison with departments and adoption of lean principles has lead to a reduction in NHS permission times for engagement in research.

Close working relationships with the Comprehensive Local Research Networks (CLRN) and the topic specific networks including Stroke, Diabetes, Cancer, Neurodegenerative Disorders and Primary Care Research Networks continue to strengthen collaborative working, serving to maximise recruitment within the Trust. The expansion of the generic nursing research team has increased the amount of support available to researchers in the Trust and enables cross cover arrangements, increasing the choice of studies available to patients and maximising engagement.

Excellent collaboration between Trust research staff and the Cardiology clinical team was demonstrated with the Paradigm heart failure study. Target recruitment was exceeded by 50%, making City Hospitals Sunderland the joint 4th highest UK recruiting site.

City Hospitals Sunderland's commitment to improving the quality of care offered to patients is demonstrated by active participation in clinical research, thus widening the choice and scope of studies available to patients. City Hospitals Sunderland recruitment of patients into NIHR portfolio studies has consistently increased over the last five years. Recruitment into studies in City Hospitals Sunderland has increased from 1416 (March 2012) to 1732 (March 2013).This figure equates to 11% of the Northumberland Tyne and Wear Comprehensive Local Research Networks (NTW CLRN) total recruitment into NIHR portfolio studies for 2012/2013.It is an increase of 200 more patients than our estimated recruitment for the year 2012/13. This means that we were one of only two member organisations within NTW CLRN that offered an estimated increase in recruitment in 2012/13 compared to 2011/12, and the only one to recruit above that estimate.

The number of patients receiving relevant health services provided or sub-contracted by City Hospitals Sunderland in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1732.

There are currently 242 research studies registered at City Hospitals Sunderland, of which 22 are commercial. City Hospitals Sunderland has a well balanced portfolio across specialties, with research in new clinical areas offering patients the opportunity to participate in trials using the latest techniques and medical treatments.

Information on the use of the CQUIN framework

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

A proportion of City Hospitals Sunderland's income in 2012/13 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 relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at *http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275*.

For 2012/13, approximately £6.45m of income (4.7m in 11/12) was attached to the delivery of quality improvements through the CQUIN framework. The Trust achieved the majority of these quality goals and has received £6.39m (99%) of CQUIN monies as a result.

The full CQUIN scheme 2012/13 and where we have achieved our targets are highlighted below:

No	Description of Goal	Indicator	Priority	Achievement of target
1	Reducing harm from Venous Thromboembolism(VTE)			
1a		% of all adult inpatients who have had VTE risk assessment on admission to hospital, using the clinical criteria of the national tool	National	
1b		Proportion of patients assessed to be at increased risk of VTE who are offered VTE prophylaxis in accordance with NICE guidance		
1c		Proportion of patients/carers who are offered verbal and written information on VTE prevention as part of the admission process		
1d		i) Proportion of all adult inpatients discharged then readmitted within 90 days for pulmonary embolism (PE)		
		ii) Identification of patients readmitted with PE and completion of root cause analysis to identify learning and implement appropriate improvements		
2	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting			
2a		Dementia screening - % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening questionnaire	National	
2b		Dementia risk assessment - % of all patients aged 75 and over, who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool		
2c		Referral for specialist diagnosis - % of all patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis		
2d		Implementation of an improvement plan linked to national dementia audit outcomes (including the measurement of LOS for dementia patients compared with other patients)	Local	
3	Safety Thermometer			
		Use of the NHS safety thermometer	National	
4	Improving patient experience			
4a		Composite measure "Improving responsiveness to personal needs of patients" from the adult inpatient survey	National	
4bi		Share a forward plan of patient experience work for 12/13	Local	
4bii		Plan to include real time feedback as well as other methods across a range of services		
4biii		Each quarter demonstrate where improvements have been made as a result of feedback from patients		
4c		Implementation of action plan following inpatient or outpatient survey results CHS - food		
5	Effective management of long term			
5a		Stroke – bundle of 12 key quality indicators (from SINAP) that 'approximate' to the NICE quality standards	Local	

5b	conditions (LTC) to improve patient outcomes and minimise readmissions	% of patients receiving all 7 indicators from the heart failure bundle		
		% of Ward E54 cohort COPD patients with COPD Discharge Bundle		
6	Reduction in harm from pressure ulcers			
6a		Implementation of an improvement plan to further develop systems and processes to prevent and manage pressure damage	Local	
6b		Total number of grade 2 and above pre-hospital and hospital acquired pressure ulcers		
6c		Total number of (new or present) ulcers which deteriorate within admission		
7	Reduce harm from falls			
7a		% of patients over 65 attending A&E as a result of a fall/ and or blackout	Local	
7b		% of patients over 65 attending A&E as a result of a fall and a blackout who have 2 or more falls in the previous 12 months who have been referred Number of patients over 65 attending A&E as a result of a fall who have sustained a fracture on this presentation and referred		
7c		% of fallers aged 65 and over referred from A&E in whom an initial assessment has been completed within 4 weeks of receipt of referral % of fallers aged 65 and over referred from A&E who has been screened for osteoporosis and in whom a subsequent treatment decision had been made		
8	To support mothers to initiate and continue breastfeeding		Local	
8a		Implement improvements in monitoring breastfeeding rates with teams and individuals		
8b		Proportion of women that initiate breastfeeding following birth		
8c		Proportion of women who initiate breastfeeding following birth and continue until discharge from midwifery care		
9	To identify patients that drink alcohol and provide brief advice aimed at reducing alcohol consumption as appropriate			
9a		Proportion of patients attending preassessment who have alcohol status recorded	Local	
9b		Proportion of those patients reporting higher levels of alcohol who have received a brief intervention		
10	To improve the standard of end of life care for patients in an acute setting			
10a		Implementation of an improvement plan in one new area (Heart Failure ward B21) and continued measurement of standards for Renal Ward following improvement work in 11/12	Local	
11	To improve productivity, clinical effectiveness and patient experience			
11a		Planned care - Completion of implementation of enhanced recovery model of care in colorectal during Q1 and implementation of model in one new area in 12/13 (knee)	Local	

	through pathway reform			
12	Improve communication			
12a		Implementation of discharge communication improvement plan	Local	
12b		Communication of results (MRI Q1/2 and gastroenterology Q3/4) • Identifying best practice/what's done elsewhere • Document improved system/process for communicating results • Implement in one clinical area • Evaluate from trust/patient/GP perspective (including benefits and resource implications) • Identify recommendations		
13	Improvements in appointments systems			
13a		Implementation of an improvement plan over 12/13 and 13/14 to: • Reduce DNA (Do Not Attend) rates • Reduce the number of cancellations • Improve the timeliness of review appointments • Reduce number of face to face appointments	Local	
14	Implementation of regional learning disabilities pathways			
14a		Implementation of regional learning disabilities pathways	Local	
15	High cost drugs audit			
15a		High cost drugs audit - randomly selected 10 patients (quarterly) care audited using NICE data collection tool	Local	
16	Trauma and Audit Research Network (TARN)			
16a		• % completeness of data submission • % achievement of standards	Local	

Note: Red indicates more than two quarters, out of four not being achieved or not achieved end of year target
Amber indicates two quarters or less, out of four not being achieved

Information relating to registration with the Care Quality Commission

City Hospitals Sunderland NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **without conditions** for all services provided.

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

The Care Quality Commission has not taken enforcement action against City Hospitals Sunderland NHS Foundation Trust during 2012/13.

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

Care Quality Commission – Mental Health Act Monitoring Visit (Feb 2013)

In February 2013, the Care Quality Commission undertook a monitoring visit on our use of the Mental Health Act (1983). The visit reviewed whether our procedures and practices were appropriate and safe for patients whose rights are restricted under the Act. The assessment involved interviews with relatives, carers, advocates, staff and managers, and reviewed various hospital records and documents.
In its narrative report summarising the outcomes of the review the Care Quality Commission identified a number of improvements that the Trust must make to ensure that it is in full compliance with the Mental Health Act (1983) legal framework and its associated Code of Practice. Actions that we will take include developing more formal agreements for the provision of mental health services in City Hospitals, improving our documentation for capacity assessments etc, and providing information leaflets and posters advising patients of their rights under the Mental Health Act (1983).

Care Quality Commission – Review of Compliance (December 2012)

The Care Quality Commission carried out a routine unannounced review visit in November 2012, when CQC inspectors visited the accident and emergency department, the medical and surgical admission units and selected wards. The review focused on the pathway people took from accident and emergency to the initial admission areas and to the ward appropriate for their condition. They spoke with patients and their visitors about their experiences of the hospital and the service they had received. In addition, they also spoke with staff and observed how patients were cared for and how staff undertook their day to day duties. The review was supported by an expert-by-experience, a person who has personal experience of using or caring for someone who uses this type of care service.

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

Standards which were checked	Standards being met
Respecting and involving people who use services	✓
Care and welfare of people who use services	✓
Safeguarding people who use services from abuse	✓
Supporting workers	✓
Records	✓

CareQuality Commission **Inspection Report**

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Sunderland Royal Hospital

Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP — Tel: 01915656256

Date of Inspection: 13 November 2012 — Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Inspection Report | Sunderland Royal Hospital | January 2013 www.cqc.org.uk 1

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

"People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care."

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

"People experienced care, treatment and support that met their needs and protected their rights"

Outcome 07: People should be protected from abuse and staff should respect their human rights

"People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening."

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

"People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard."

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

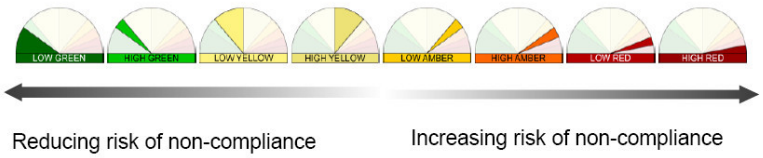
"Staff records and other records relevant to the management of the services were accurate and fit for purpose. Records were kept for the appropriate period of time and then destroyed securely."

Trust CQC Quality Risk Profile

The CQC provides a quality risk profile (QRP) for all NHS Trusts. The QRPs are updated on a regular basis and take into consideration all information, both internal and external, which is collected in relation to the relevant Trust. They are used to help monitor compliance against the CQC Essential Standards of Quality and Safety. More information on the essential standards and other CQC assessments can be found on the following link: www.cqc.org.uk

The Trust QRP ratings can be seen below as reported during 2012. There are **eight ratings** that can be assigned to Trusts. The highest possible (best) rating is low green and the lowest (worst) possible rating is high red. An additional two criteria for no data or insufficient data (in order to calculate a risk rating) are also used. City Hospitals has received no 'at risk' ratings from the Care Quality Commission during 2012/13, i.e. no ratings in the amber or red sections which would denote an increasing risk of non-compliance with the essential standards of quality and safety.

	Outcome Description	Risk rating								
		May 2012	June 2012	July 2012	Sept 2012	Oct 2012	Nov 2012	Jan 2013	Feb 2013	March 2013
1	Respecting and involving people who use services	Low yellow	Low yellow	Low green	Low green	High green	High green	High green	Low yellow	High green
2	Consent to care and treatment	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	High green	High green	High green	High green
4	Care and welfare of people who use services	Low yellow	Low yellow	Low yellow	High green	High green	Low yellow	High green	High green	Low green
5	Meeting nutritional needs	Low yellow	Low yellow	High green	High green	High green	High green	High green	High green	High green
6	Cooperating with other providers		Low yellow	Low yellow	Low green	High green	Low green	Low green	Low green	High green
7	Safeguarding people who use services from abuse			High green	High green	High green	High green	Low green	Low green	Low green
8	Cleanliness and infection control	High green	High green	Low green	Low green	Low green	Low green	Low green	Low green	Low green
9	Management of medicines	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow
10	Safety and suitability of premises	Low yellow	Low yellow	High green	High green	High green	Low green	High green	High green	High green
11	Safety, availability and suitability of equipment	Low yellow	Low yellow	Low green	Low green	Low green	Low green	Low green	Low green	Low green
12	Requirements relating to workers	High green	High green	High green	Low green	High green	High green	High green	High green	Low yellow
13	Staffing	Low green	Low green	Low green	Low green	Low green	Low green	Low green	Low green	Low green
14	Supporting staff	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow
16	Assessing and monitoring the quality of service provision	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow
17	Complaints	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow	Low yellow
21	Records	Low green	Low green	Low green	Low green	Low green	Low green	Low green	Low green	Low green



Information on the quality of data

City Hospitals Sunderland submitted records during 2012/13 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS number was:	%	Which included the patient's valid General Practitioner Registration Code was:	%
Percentage for admitted patient care	99.9%	Percentage for admitted patient care	100%
Percentage for outpatient care	99.9%	Percentage for outpatient care	100%
Percentage for accident and emergency care	99.2%	Percentage for accident and emergency care	100%

Information Governance Toolkit

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

Annual ratings of green (pass) or red (fail) are assigned to Trusts each year. The final submission of the Toolkit had to be made by the 31 March 2013. City Hospitals Sunderland Information Governance Assessment Report overall score for 2012/13 was 84% and was graded Green (satisfactory). Church View Medical Centre's (managed by City Hospitals Sunderland) submission for 2012/13 was 88% and is also graded Green (satisfactory).

The following table shows progress with ratings when compared to the previous year.

Requirement	2011/12 rating	2012/13 rating	Comparison
Information governance management	86%	86%	⇔
Corporate Information Assurance	66%	77%	✓
Confidentiality and Data Protection assurance	75%	75%	⇔
Secondary use assurance	91%	95%	✓
Information security assurance	82%	82%	⇔
Clinical information assurance	93%	93%	⇔
All initiatives	**83%**	**84%**	✓

⇔ = same score

As in previous years, Sunderland Internal Audit Services (SIAS) has been engaged in the process and has audited the recommended toolkit submissions for both City Hospitals and Church View. SIAS have assessed that:

- appropriate governance arrangements are in place, and
- from the evidence, that the submitted IG Toolkit scores are a reasonable assessment of current performance.

The following assurance has been provided in the report from SIAS:

"On the basis of work carried out, significant assurance can be given that there is a generally sound system of internal control designed to meet the Trust's objectives and that controls are generally being applied consistently."

Clinical coding error rate

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

City Hospitals Sunderland was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Sample reviewed (number)	% Primary diagnosis incorrect	% Secondary diagnosis incorrect	% Primary Procedures incorrect	% Secondary Procedures incorrect
Musculoskeletal disorders (50)	20.0	15.7	6.7	33.3
Thoracic procedures and disorders (50)	6.0	11.2	0.0	6.3
Female reproductive system procedures (50)	2.0	14.7	8.0	19.0

Accident & Emergency data (attendances tested)	% investigation codes incorrect	% treatment codes incorrect
75	82.5	61.5

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.

City Hospitals Sunderland will be taking the following actions to improve data quality:

Accident and Emergency

The Trust's Data Quality department is working with the A&E team to improve the recording of key data items especially in the recording of ethnicity.

Small Systems

The Trust has recently expanded the Data Quality Policy to include departmental small systems (those areas that do not use the hospital's main system – HISS). A key area of work for 2012/13 has started with data quality staff and analysts reviewing the accuracy of the data held in these small systems. A programme of checks and audits is now being followed and the objective is to improve the accuracy of data held within them if required.

Part 2C: National core mandatory indicators

This section reports on a set of mandatory national quality indicators and compares performance with other hospitals

2C Review of national core mandatory indicators

For 2012/13, the Department of Health has asked Trusts to report on a mandatory set of core quality indicators which uses a standardised format to enable comparison of hospital performance. Not all the indicators are relevant to our Trust; some depend on the services which are provided.

The indicators are linked to the NHS Outcomes Framework, which provides an overarching plan for delivering improvements and good clinical outcomes across the NHS, and are based on five 'domains of care'. The indicators relevant to City Hospitals, aligned to the outcome domains, are shown below:

Outcome Framework domain	Indicator
Domain 1: Preventing people from dying prematurely	Summary hospital-level mortality indicator (SHMI)
Domain 2: Enhancing quality of life for people with long-term conditions	*No indicators relevant to City Hospitals*
Domain 3: Helping people to recover from episodes of ill health or injury	Patient reported outcome scores (PROMS)
	Emergency readmissions to hospital within 28 days of discharge
Domain 4: Ensuring that people have a positive patient experience	Responsiveness to inpatients' personal needs
	Percentage of staff who would recommend the provider to friends or family needing care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	Percentage of admitted patients risk assessed for VTE
	Rate of *Clostridium difficile*
	Rate of patient safety incidents and percentage resulting in severe harm or death

Domain 1: Preventing people from dying prematurely

This is about reducing premature mortality from some of the major causes of death, for example, heart disease, chest disease, liver problems and cancer

1 Mortality - Summary hospital-level mortality indicator (SHMI)

Mortality rates are an important, but controversial, marker of the quality of care that a hospital delivers. The NHS now has a number of different ways to measure mortality, which can be confusing as each method uses slightly different approaches. However, each shares a common understanding of mortality as the measure, either a rate or ratio, of the actual number of deaths against the expected number of deaths. As a single indicator of quality, mortality is akin to a smoke alarm; it may signal something serious, but more often than not it will 'go off' for reasons unrelated to quality of care. But, like smoke alarms, hospital mortality figures should never be ignored.

In 2011 the new Summary Hospital-level Mortality Index (SHMI) was published by the NHS Information Centre. The indicator provides a common standard and transparent methodology for reporting mortality at Trust level. A Trust's SHMI value is the ratio between the actual number of patients who die following treatment and the number that would be expected to die, on the basis of average national figures given the characteristics of the patients treated.

The baseline SHMI value is 1. A Trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology. A score higher than 1 shows more deaths than expected and below 1 there will have been fewer deaths. Each SHMI score is also accompanied by a banding decision as either:

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

There have been **seven** publications of SHMI since the first release in October 2011.

a) SHMI values and banding (April 2010-September 2012)

Indicator	April 10-March 11	July 10-June 11	Oct 10-Sept 11	Jan 11-Dec 11	April 11-March 12	July 11-June 12	Oct 11 – Sept 12
City Hospital's SHMI value	1.06	1.01	0.98	0.94	0.91	0.92	0.93
City Hospital's SHMI banding	**Band 2**	**Band 2**	**Band 2**	**Band 2**	**Band 2**	**Band 2**	**Band 2**
National average	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Highest SHMI value – national (*high is a worse position*)	1.21	1.21	1.22	1.24	1.24	1.25	1.21
Lowest SHMI value – national (*low is a better position*)	0.67	0.67	0.67	0.69	0.71	0.71	0.68

Data Source – Health & Social Care Information Centre

The seven SHMI publications to date show that City Hospitals has a Band 2 **'as expected'** mortality rating; the majority of NHS Trusts are banded at this level. In the last five SHMI publications, to date, the actual number of deaths has been fewer than the expected number, i.e. any score less 1.0.

b) Percentage (%) of patients whose treatment included palliative care

Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness. The coding of palliative care in a patient record has a potential impact on hospital mortality. The SHMI makes no adjustments for palliative care coding (unlike some other measures of mortality), so all patients who die are included, not just those expected to die.

Indicator	April 10-March 11	July 10-June 11	Oct 10-Sept 11	Jan 11-Dec 11	April 11-March 12	July 11-June 12	Oct 11 – Sept 12
% of patients admitted to the Trust whose treatment included palliative care	0.7	0.8	0.8	0.8	0.8	0.8	0.8
National average	0.9	0.8	0.9	0.9	1.02	1.05	1.07
Highest Trust score	2.91	3.0	3.2	3.2	3.3	3.3	3.2
Lowest Trust score	0.0	0.0	0.0	0.0	0.0	0.0	0.0

% of patients admitted to the Trust whose deaths were included in SHMI and whose treatment included palliative care	11.1	12.5	13	13	13	11.9	11.5
National average	16.72	16.14	16.59	17.31	18.1	18.6	19.2
Highest SHMI value – national	38.95	40.1	41.6	41.7	44.2	46.3	43.3
Lowest SHMI value – national	0.11	0.1	0	0	0	0.3	0.2

Data Source – Health & Social Care Information Centre

The Dr Foster Hospital Guide (2012) 'Fit for the Future' also highlighted 'as expected' and 'lower than expected' Trust performance for four important measures of mortality; Hospital Standardised Mortality Ratio (HSMR), SHMI, deaths after surgery, and deaths in low-risk conditions.

City Hospitals Sunderland considers that this data is as described for the following reasons;

- The data shows an improving picture of mortality using the SHMI methodology, in addition to other alternative measures of mortality, i.e. RAMI and HSMR, and
- The Trust is proactive in monitoring mortality and in investigating and explaining variations in mortality performance,

City Hospitals Sunderland intends to take the following actions to improve the indicator and percentage in a) and b), and so the quality of its services, by;

- Ensuring that clinical directorates and specialties undertake routine mortality/morbidity review meetings and implement changes in practice, where necessary,
- Strengthening and refining our monitoring of mortality (using CHKS information and analysis) and ensuring that any outlier performance or variation is properly investigated and reported, and
- Developing a Trust wide mortality review and monitoring policy, which will provide a consistent framework for reflecting, sharing and acting on the findings of mortality review.

Domain 3: Helping people to recover from episodes of ill health or injury

The focus is on helping people to recover as quickly and as fully as possible from ill health or injury, and can be seen as two complementary objectives: preventing conditions from becoming serious (wherever possible), and helping people to recover effectively.

2 PROMS - Patient reported outcome scores

PROMS provide an important means of capturing the extent of the improvement in health following surgery or ill health as reported by patients. Trusts are required to report on relevant patient-reported outcome measures PROMs, which currently include four elective NHS procedures, Hip or Knee replacements, Groin Hernia surgery and Varicose Vein procedures.

PROMS are short, self-completed questionnaires. They measure the patient's health status or health related quality of life at a single point in time. The first questionnaire is given during the patient's preoperative assessment or on the day of admission. A second questionnaire is sent six months from date of surgery. For varicose vein and groin hernia procedures, the survey is sent out three months following surgery. Information about our PROMS performance across the four elective procedures (hip & knee replacement, varicose veins and hernia surgery) are highlighted below:

PROMS measure (EQ-5D index)	2011/12 Adjusted average health gain	2012/13* Adjusted average health gain	National average* (2012/13)
Patients reporting an improvement following **hip replacement**	0.383	0.400	0.429
Patients reporting an improvement following **knee replacement**	0.307	0.261	0.312
Patients reporting an improvement following **varicose vein** procedures	0.07	0.055	0.089
Patients reporting an improvement following **groin hernia** procedures	0.081	0.095	0.874

Data source – Health & Social Care Information Centre – Dataset 18: PROMS

* Reporting period April 12 – December 2012

City Hospitals Sunderland considers that these outcome scores are as described for the following reason;

- That our patients, in most cases, are self-reporting improvements in their general health following their treatment at the Trust.

City Hospitals Sunderland intends to take the following actions to improve these outcomes, and so the quality of its services, by:

- Sharing and reflecting on the results of our PROMS participation with key members of the clinical team, and
- Providing clinician-level data to enable comparison with peers and facilitate review of individual/team performance. This will be used to stimulate review and change within the patient pathway.

3 Emergency readmissions to hospital within 28 days of discharge

Whilst some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care.

At the time of publication, the full data set has not been made available from the Health & Social Care Information Centre. The Trust is therefore unable to compare performance with the national average and with those Trusts with the highest and lowest scores.

% of patients readmitted to hospital within 28 days of being discharged from hospital	0-14 years	15 and over
2011/12	2.48%	1.80%
2012/13	5.17%	5.70%

City Hospitals intends to take the following actions to improve this data, and so the quality of its services, by;

- Continuing to report our re-admission performance to the Board and discuss plans to reduce unnecessary re-admissions at quarterly performance reviews with Directorates,
- Developing re-admission avoidance schemes which include appropriate quality discharge arrangements as well as linking with community service providers to ensure appropriate onward care. This also includes services we have developed such as clinics providing by a community geriatrician to prevent emergency admission into hospital.

Domain 4: Ensuring that people have a positive patient experience

The views and experiences of patients and their interactions with our clinical and non-clinical staff matter. They can provide us with valuable information which we can use to drive improvements and create a better service.

4 Responsiveness to inpatients' personal needs

A composite score of 'responsiveness to the personal needs of patients' was set as part of our CQUIN scheme and is measured by aggregating the scores from five individual survey questions in the 2012 national adult inpatient survey. The results are shown in the table below; the higher the score out of 100, the better.

Composite score	2010/11	2011/12	2012/13
National average	67.3	67.4	68.1
City Hospitals Sunderland	68.3	71.4	68.9

Data source - Health & Social Care Information Centre / National Adult Inpatient Survey 2012

City Hospitals Sunderland considers that this data is as described for the following reason;

- The results in 2012/13 show again that our performance is better than the national average but we are disappointed that we were unable to exceed the improved composite score from last year despite a challenging year in terms of activity.

City Hospitals intends to take the following actions to improve this data, and so the quality of its services, by;

- Ensuring that these questions are reflected in the internal real time feedback questionnaire which provides a continuous mechanism of review to the annual survey. Any poorly performing wards will be held to account in terms of improving their performance. The process will be monitored by the Matrons, and
- Providing a quarterly update on performance linked to the real time feedback report presented to the Patient, Carer and Public Experience Committee.

5 Percentage of staff who would recommend the provider to friends or family needing care

How members of staff rate the care of their local hospital is recognised as a meaningful indication of the quality of care and a helpful measure of improvement over time. One of the questions asked in the annual NHS Staff Survey includes the following statement: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust".

Indicator	2010	2011	2012	National average
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust"*	57%	59%	63%	60%

Source – NHS Staff Survey 2012

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

City Hospitals Sunderland considers that this percentage is as described for the following reasons;

- We have shown year on year improvement on the percentage of staff who would recommend the Trust to their family and friends if they required treatment and care, and
- The Trust has ensured that quality and improvement are part of our strategic aims, vision and aspirations. Our corporate objectives and operational planning with directorates and specialties incorporate our key delivery areas, such as 'best quality' and 'highest safety' as well as focusing on leadership and staff morale as precursors to providing high quality care.

City Hospitals Sunderland intends to take the following actions to improve this percentage, and so the quality of its services, by;

- Developing an action plan that sets out to strengthen our engagement with all levels of staff, to keep them informed and involved about what is happening in City Hospitals and making sure that staff understand that quality, care and compassion are our guiding principles in everything we do,
- Providing information to staff via staff briefings and road shows about how the organisation intends to meet the challenges of the Francis Report and what opportunities there will be to further enhance quality across the organisation, and
- Ensuring that front line staff influence and play an active part in the transformation and reform of our emergency care pathways and supporting services.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients should expect to be treated in a safe and clean environment and to be protected from avoidable harm. In recent years the NHS has made progress in developing a culture of patient safety which can involve many things: treating patients with dignity and respect, high quality clinical care, creating systems that prevent both error and harm, and learning from patient safety incidents, particularly events that should never happen, to prevent them from happening again.

6 Percentage of admitted patients risk assessed for VTE

An estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year. VTE is a condition in which a blood clot (a thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis (DVT). The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

Venous thrombosis often does not have symptoms; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, sometimes over a longer term because of chronic venous insufficiency (when your leg veins cannot pump enough blood back to your heart).

The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and concomitant conditions).

Our CQUIN target for 2012/13 was that more than 90% of patients would receive a risk assessment for VTE.

% of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE)

2011/12				2012/13				
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	National average
91.5%	91.9%	92.9%	92.1%	91.2%	91.7%	92.3%	94.4%	Not available*
92.1%				92.4%				

Data source - Health & Social Care Information Centre (H&SCIC)
* Not available from the H&SCIC at the time of publication

City Hospitals Sunderland considers that this percentage is as described for the following reasons;

- The whole VTE assessment and management pathway has been reviewed and revised to incorporate the requirements of national best practice guidance such as NICE and the recommendations of national bodies such as the All-Party Parliamentary Thrombosis Group,

- The risk assessment process now has an electronic platform and a mandatory ruling that the assessment must be undertaken, and
- The VTE Committee has overseen the implementation of the new VTE risk assessment pathway and regularly monitors ward compliance and acts on any areas of sub-optimal compliance.

City Hospitals Sunderland intends to take the following actions to improve this percentage, and so the quality of its services, by;

- Making further enhancements to the current VTE pathway to ensure that it is able to meet the more challenging national CQUIN target of more than 95% of patients being risk-assessed, and
- Reviewing and assessing our compliance with the new NICE Quality Standard 23 (Management of Venous Thromboembolic Disease).

7 Rate of *Clostridium difficile*

C. *difficile* can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel, but hospital-associated C. *difficile* can be preventable. This measure looks at the rate per 100,000 bed days of cases of C.*difficile* infection reported within the Trust among patients aged 2 or over.

At the time of publication, the full data set has not been made available from the Health & Social Care Information Centre. The Trust is therefore unable to compare performance with the national average and with those Trusts with the highest and lowest scores. However, we are able to report Trust performance using locally sourced information.

	April 12 – March 13
Rate per 100,000 bed days of cases of C.*difficile* infection reported within the Trust among patients aged 2 or over	24.30%

Data source – Calculation from City Hospitals Performance Department

City Hospitals Sunderland intends to take the following actions to improve this rate, and so the quality of its services, by;

- Increasing the availability of isolation facilities within the Trust,
- Reviewing Infection Prevention and Control education and training provision for hospital staff, patients and their carers,
- Developing a programme for enhanced deep cleaning of wards, which will include hydrogen peroxide fogging (a disinfection method used to eradicate or significantly reduce infection),
- Undertaking an audit of decontamination of medical equipment,
- Introducing a screening programme for elderly care patients, and
- Increasing the analysis of antimicrobial prescribing by clinicians,

8 Rate of patient safety incidents and percentage resulting in severe harm or death

An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The rate of reported patient safety incidents i.e. unintended or unexpected incidents which could have led, or did lead, to harm for patients, should increase at least in the short term as the reporting culture improves, whilst the numbers of incidents resulting in severe harm or death should reduce.

This indicator has been subject to limited assurance from our external auditors as mandated by Monitor. The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to below;

- Patient safety incidents are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare,
- An incident causing 'severe harm' may include; major injury leading to long-term incapacity/disability, an increase in length of stay by more than 15 days, and mismanagement of care with long term effects,
- An incident which leads to unexpected death of a patient.

The table below shows the comparative reporting rate, per 100 admissions, for large acute NHS organisations. For the most current reporting period (April – September 2012), City Hospitals has a reporting rate of 5.1 incidents per 100 admissions, which is below the 6.2 national average. However, this is an improvement from the rate of 4.3 in the previous period (October 2011 - March 2012) which positioned the Trust in the lowest 25% of reporters (red section). Organisations that report more incidents usually have a better and more effective safety culture. This current rate now moves the organisation into the middle 50% of reporters (amber section) which reflects the work which has been done during the year to promote incident reporting among staff.

	CHS reporting rate*	National average
1 April 2010 to 30 September 2010	5.2	5.4
1 October 2010 to 31 March 2011	5.4	5.7
1 April 2011 and 30 September 2011	5.0	5.9
1 October 2011 – 31 March 2012	4.3	5.9
1 April 2012 – 30 September 2012	5.1	6.2

Source – Organisation Patient Safety Incident Report (NHS Commissioning Board)
* Incidents reported per 100 admissions

The table below shows incidents reported resulting in severe harm or death. The current rate of severe harm is similar to that in previous reporting periods although there has been an increase in incidents resulting in patient deaths compared to the last report (1 October 2011 – 31 March 2012).

Incidents reported by degree of	Severe harm	Death
1 April 2010 to 30 September 2010	47 (1.5%)	8 (0.3%)
1 October 2010 to 31 March 2011	57 (1.8%)	10 (0.3%)
1 April 2011 and 30 September 2011	33 (1.1%)	8 (0.3%)
1 October 2011 – 31 March 2012	21 (0.8%)	2 (0.1%)
1 April 2012 – 30 September 2012	28 (0.9%)	10 (0.3%)
1 April 2012 – 31 March 2013*	72 (0.9%)	7 (0.1%)**
National rates (April – Sept 2012)***	0.6%	0.1%

Source – Organisation Patient Safety Incident Report (NHS Commissioning Board)
* Information from City Hospitals 'Safeguard' system
** See note immediately below
*** All large acute organisations

When validating the data for the National Reporting & Learning System (NRLS) in advance of the close off date of 31st May which facilitates the production of the report for Oct 2012 – March 2013 it was recognised that whilst 20 deaths had initially been reported, on completion of the internal investigation and validation process only 5 of these incidents had either caused or contributed to death. The remaining incidents required their grading to be lowered. This prompted a revalidation of the April 2012 – Sept 2012 data which highlighted that of the 10 deaths initially reported 2 were found to have caused or contributed to death and the remainder required regrading. Unfortunately as the NRLS database collection for this period had

closed in February to facilitate production of the April 2012 – Sept 2012 report it has not been possible to correct the NRLS data for this period.

As a result of these findings a process to ensure monthly revalidation exercises take place has now been implemented in order to identify and regrade incidents appropriately at the earliest possible opportunity.

City Hospitals considers that this number and rate is as described for the following reasons;

- There has been an increase in incidents reported under the categories of severe harm and death as a consequence of changes in the Coroner's process. The organisation has reported deaths which have occurred as a recognised complication of treatment meeting requirements for transparency and openness with families. These patient deaths are part of the local Coroner's Inquest process, and
- We have traditionally had a culture of low reporting of incidents, in particular those categorised as 'near miss' or low degrees of harm.

City Hospitals Sunderland intends to take/has taken the following actions to improve this number and rate, and so the quality of its services, by;

- Simplifying and making more accessible to staff the Safeguard Incident Reporting Form, which is on the Trust's intranet,
- Launching a Trust-wide campaign to 'Keep calm and carry on reporting incidents',
- Identifying low reporting staff groups and targeting them as part of the above campaign, e.g. non-clinical staff,
- Explaining the feasibility of sending an automated response to the incident reporter thanking them for reporting the incident,
- Introducing screen shots on the Trust intranet advertising the importance of incident reporting, and
- Holding training in directorates on incident reporting and risk management.

Part 3: Review of Quality Performance 2012/13

Part 3 of this Quality Report provides an opportunity for the Trust to report on progress against the quality priorities that were agreed last year.

Where possible, we have provided additional sources of (external) data to provide members of the public with as much information as possible

Part 3A describes Trust performance against a set of local quality indicators

Part 3B highlights additional information about our quality performance

Part 3C summaries performance against key national priorities 2012/13

Annex One contains statements from our key stakeholders

Annex Two contains statements of director's responsibilities in respect of the Quality Report

Part 3A Trust performance against a set of local quality indicators

During 2012/13 we agreed to measure, monitor and report a limited number of key indicators selected by the Board in consultation with key stakeholders, in each of the dimensions of quality; patient safety, clinical effectiveness and patient experience. Some of these indicators have now been included in the core list of mandatory indicators (**see Section 2C**) where performance has already been highlighted.

a) Discharge communications to Primary Care

The focus of the measure was to improve the quality and timeliness of discharge communication between the Trust and Primary Care (G.P's and their healthcare teams). This formed part of the CQUIN improvement goal 'Improve Communication' for 2012/13.

Completed on eDischarge (%)											
Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
83.18	85.44	84.79	83.67	84.22	75.73	76.51	88.42	90.67	89.48	89.59	88.59
Completed within 24 hours* (%)											
66.26	67.48	67.58	68.26	74.03	64.94	63.42	60.93	66.21	63.73	68.02	64.96

Data source – Figures derived using local specifications

*It has been recently identified that there are data reporting issues which may affect the Trust's performance for the proportion of discharge summaries issued in 24 hours. This is currently being investigated so this information should be viewed with caution.

- Part of the requirements for CQUIN was to produce and complete an improvement plan, which would document how the Trust was expected to improve the proportion of discharge summaries issued within 24 hours, the quality of content and progression towards electronic distribution of discharge summaries,
- Regular and detailed reporting has been introduced to monitor discharge communication performance at specialty and ward level in order to reduce variation within the Trust and help to identify areas with the greatest scope for improvement in terms of both utilisation of the eDischarge system and timeliness of completions. This is discussed regularly at monthly Performance & Contracting meetings with Commissioners as well as at quarterly review meetings. It has also been supplemented by daily reporting to highlight to the relevant Directorates any discharge communications that have not yet been completed for patients discharged the previous day, and
- Discharge communications quality and performance is now led by the Trust's Clinical Directors.

b) Never events

The underlying principle for the introduction of never events is to ensure that organisations report and learn from serious incidents and strengthen their systems for prevention in the future.

Description of Goal	09/10	10/11	11/12	12/13
Preventing occurrence of any 'Never Events'	Not available	Not available	4	1

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, e.g. wrong site surgery, mis-placement of naso-gastric tube, retained instruments / swabs post –surgery, wrong route administration of chemotherapy etc (National Patient Safety Agency definition)

An incident report was submitted in March 2013 identifying that a patient had attended theatre for a planned operative procedure. Following the surgery, we were unable to account for a small fragment of the probe that was used as part of the surgical procedure. It was initially thought that this was attached in some way to the tissue sample that was removed for laboratory analysis; however it appears that the fragment had been unintentionally left within the patient. The incident is currently being fully investigated using the root cause analysis process, and any corrective actions identified will be taken immediately.

c) Readmission of patients with chronic chest problems

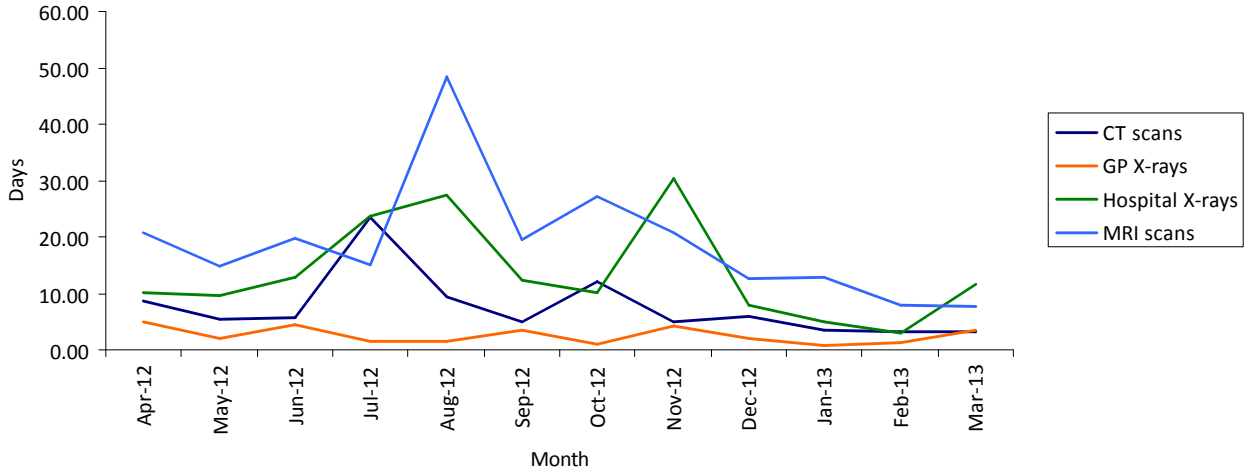
Patients with chronic chest complaints account for a significant percentage of admissions to hospital; the evidence suggests that some of these patients could be avoided and more appropriately managed in the community and at home.

	Indicator	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
To reduce the number of COPD readmissions	28 days	18.85%	23.32%	23.87%	25.68%	22.40%	25.1%
	30 days	19.11%	23.96%	25.11%	26.77%	21.06%	24.4%

COPD Readmission data based on HRG codes: D39/ D40 – COPD or Bronchitis, with and without complications, readmissions at 30 and 28 days.

d) Reporting times for radiology

The timeliness and reliability of radiology reporting was highlighted as a priority area of improvement for the Trust. The aim was to reduce reporting times for hospital x-rays and scans and implement an electronic system for ordering and delivering of reports. Through the adoption of LEAN methodology, the radiology team have internally restructured the way in which the service is delivered.



Description of Goal	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Improve internal reporting times for x-ray and ultrasound scans – (exam to report average in days)												
CT Scans	8.5	5.5	5.5	23.5	9.4	4.8	12.1	5.0	6.0	3.3	3.1	3.1
GP X-rays	4.8	1.8	4.3	1.4	1.4	3.4	0.9	4.3	2.0	0.7	1.1	3.5
Hospital X-rays	10.2	9.5	12.9	23.6	27.3	12.2	10.1	30.3	7.9	5.0	2.9	11.6
MRI Scans	20.8	14.7	19.7	15.0	48.4	19.5	27.2	20.8	12.	12.8	7.9	7.6

Data source – Figures derived using local specifications

- The number of referrals for all exam types have been significantly higher than last year and have generally been increasing throughout the year to date. Despite this, recent performance has shown that exam to reporting times are at their best position across the year to date,
- Reporting times have been distorted throughout the year by a backlog of reports that have been identified by the implementation of the new Radiology information system. The backlog mainly consists of exams taken on multiple body parts for a given patient, which will have already been reported on in a full report that has been assigned to a single scan, although the other related exams remain outstanding because their status simply has not been updated to 'reported'. If this is identified at a later date the actual date of report completion cannot be entered retrospectively in HISS, so that these figures do in fact contain inaccuracies that result in longer exam to report times than the true position,
- Two new consultants started during the summer, which combined with the induction and training on the new Voice Recognition technology has had a positive impact upon performance, and
- Reporting is also completed via offsite reporting teams in order to help the department reduce the backlog and meet the current demand. The Directorate is close to launching a semi automated tool to send offsite images for reporting.

e) End of life care

The Liverpool Care Pathway (LCP) is an integrated care pathway that is used at the bedside to improve standards of care for patients who are dying and in the last hours and days of life. The LCP is now being rolled out not only to those in hospice care but also in other healthcare settings. Against the background of ongoing national controversies and some criticism of the pathway and the links with the CQUIN payment framework, the pathway will continue be used in City Hospitals to ensure a planned and appropriate plan of care for those at the end of life. The End of Life Steering Group will continue to oversee the implementation and evaluation of the pathway.

Description of Goal	2010/11	2011/12	2012/13
3. Increase the number of patients on the Liverpool Care Pathway as a proportion of those expected to die	62.96%	75.97%	70.23%

Data source – Figures derived using local specifications based on a quarterly sample audit

Achievements during 2012/13,

- The 'Death Matters' clinical symposium was held in September 2012, led by the Specialist Palliative Care Team to raise the profile of Palliative and End of Life Care within the Trust. The symposium attracted 123 staff members with external speakers, breakout sessions and poster presentations. Several relatives of patients were involved in presenting at the symposium. Another event is being planned for October 2013,
- Plans are in place to develop an information leaflet to provide advice to patients on Opioids (palliative care painkillers), and
- During 2013 the End of Life Steering Group will support the implementation of the 'Deciding Right' programme. This is a North East wide initiative - the first in the UK - to integrate the principles of making advance care decisions for all ages. It brings together advance care planning, the Mental Capacity Act, cardiopulmonary resuscitation decisions and emergency healthcare plans. This is being rolled out/used from 1st April 2013.

f) Improving the patient experience

In setting out our indicators for 2012/13 under the theme of patient experience, we agreed to monitor the following areas from our participation in the annual inpatient survey;

Metric	Description of Goal	07	08	09	10	11*	12*
1. Overall satisfaction	Increase the % of patients who reported "Overall how would you rate the care you received" (% of patients who said 'Good' and above)	77	77	77	80	8.0	7.8**
2. Privacy & dignity	Maintain or improve patient experience of privacy & dignity (Inpatients only)	88	89	88	90	9.0	8.8
3. Medication Side effects	Staff informed patients about medication side effects	47	53	51	52	5.6	5.3

Data source – Adult inpatient survey (2012)

* Inpatient Survey report changed; each trust now receives a score out of 10 for each question

** The question asked in the 2012 survey is slightly different and has been reworded to the one that was used in the previous year.

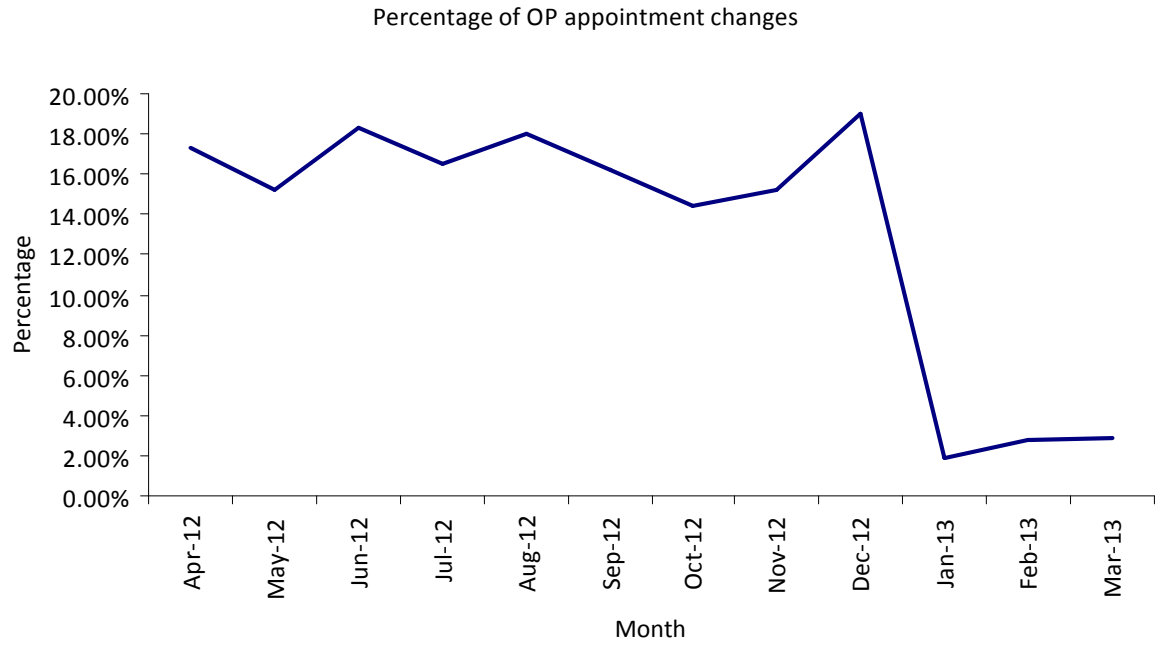
g) Outpatient Appointments Cancelled/Changed by the Hospital

Patients reported that the hospital frequently changed their outpatient appointment. The score from the National Outpatient Survey (2011) gave the Trust a 'red' category rating and performance within the worst 20% of Trusts. The Trust hoped to reduce the percentage of appointment changes in 2012/13. This formed part of the CQUIN improvement goal 'Improvements in Appointment Systems' for 2012/13.

Indicator - % Outpatient Appointment Changes

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
17.29	15.19	18.33	16.51	18.03	16.17	14.42	15.27	18.98	1.93	2.83	2.89

Data source – Figures derived using local specifications



- Part of the requirements for CQUIN was to produce and complete an improvement plan, which would document how the Trust was expected to improve the proportion of cancelled appointments, along with reducing 'did not attend' (DNA) rates, improving the timeliness of review appointments and reducing face to face appointments. This is incorporated as part of the Trust's Corporate Outpatient project,
- The improvement plan was focused on capacity and demand analysis at specialty level and sought to target areas that performed significantly worse than the norm within the Trust. This also included a detailed analysis of cancelled clinics and in particular those cancelled at short notice in order to fully understand why this was occurring. This will also tie in with the launch of the Trust's new patient administration system and the improvements that will bring in terms of being able to plan and coordinate the patients pathway through the required hospital services, and
- Performance has been improved recently due to collaborative working between the Department of Performance & Improvement, individual Directorates and the Outpatients Department. These improvements help the Trust to monitor appointment changes as experienced by patients more accurately and include the initiative to change to sending out appointment letters 5 weeks prior to a patient's appointments taking place.

3B Additional information about our quality improvements

Focusing on safety

a) Dr Foster Good Hospital Guide 2012

City Hospitals Sunderland has been rated as one of the top performing Trusts in the country by Dr Foster Intelligence (a provider of healthcare information solutions) in their 2012 Hospital Guide. The guide, an independent assessment of NHS hospitals, is based on patient data provided by hospitals and benchmarks the performance of every NHS hospital in England.

In previous Hospital Guides, the focus has been on reporting a broad range of quality measures. However, this year's guide has also included efficiency metrics in order to provide a more comprehensive view of care.

We are delighted that the Dr Foster report shows that the Trust is one of the top 40 hospitals in the country and the best in the North East for 3 out of the 4 mortality death rate measures (and in the top 50 nationally for the 4th measure). We are committed to providing the highest levels of safety for our patients and that is reflected in the report. We are also pleased that in addition to low mortality the Dr Foster report also recognises the strong Trust performance on efficiency indicators such as readmissions, outpatient attendance rates, excess bed days, long stay surgical patients cancelled operations etc. The Trust is also the top performing hospital in the North East on the combined efficiency/mortality measure.

b) CHKS Top 40 Hospitals Award

The Trust has received national recognition for its performance and achievements in healthcare quality and improvement through the CHKS Top 40 Hospitals Award. The Top 40 Hospitals Award is given to the 40 top-performing CHKS client Trusts and the rankings are based on key measures of quality, including clinical effectiveness, patient experience and quality of care. All NHS Acute Trusts are entered into the survey, which is run every year by CHKS, another independent provider of healthcare intelligence services. The accolade means that for the second year in a row the Trust has been recognised for its performance in key areas that are crucial to delivering good patient care.

c) Safe Surgery Week

The national bodies, Patient Safety First and the Clinical Board for Surgical Safety, hosted a Safer Surgery Week during September 2012. The purpose of the week was to enable staff to focus on the importance of safer surgery for patients. A series of local events for staff was organised to support aspects of safety in surgery and showcase good practice to members of the Executive Team.

During the week members of the Executive Team visited wards and departments to see 'in action' how clinical staff were delivering safer surgery for patients. This included visits by Directors to the Block Room in D Level Theatre, Ward D43, Sunderland Eye Infirmary and Ward D46. They all provided very positive feedback on their respective visits to clinical areas and enjoyed the opportunity to meet with patients and staff.

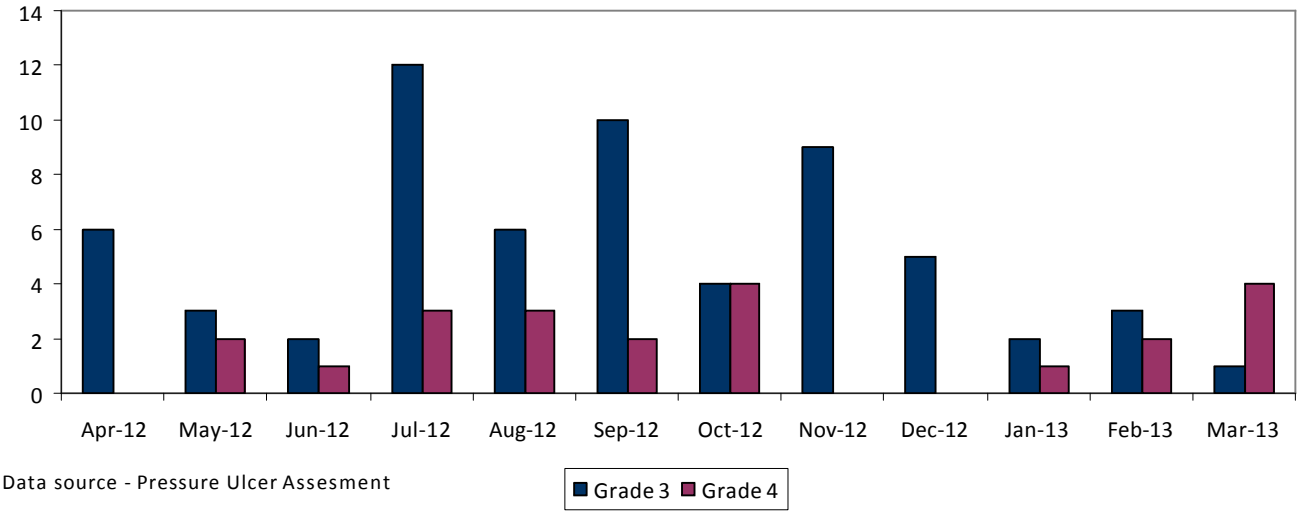
Focusing on clinical effectiveness

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

Pressure ulcers are a significant burden on the NHS and have a detrimental effect on patients' health and wellbeing. They are considered to be a proxy measure of the quality and safety of care patients receive and thereby the standard of clinical care. Pressure ulcers are more likely to occur in patients who are malnourished, elderly and obese and those with underlying medical conditions. As an organisation we are committed to reducing harm to our patients from pressure damage. Our efforts are focused on preventing them from happening, although some patients may already have pressure ulcers when they are admitted.

The table below shows our performance over the year, i.e. the number of grade 3 and 4 hospital acquired pressure ulcers reported in 2012/13.

Number of pressure ulcers grade 3 and 4 > 72 hours (hospital acquired)



Data source - Pressure Ulcer Assesment

Year	Grade 3	Grade 4	Total
2011/12	53	22	75
2012/13	63	22	85

Performance on the NHS Safety Thermometer

For the period 1st April 2012 to 31st December 2012 City Hospitals has been identified as an outlier for 'new' pressure ulcers. This means that we have reported more hospital acquired pressure ulcers compared with our peers using the national criteria. Our position within the national Safety Thermometer framework is a concern and the Tissue Viability Group have already led and coordinated a number of new initiatives to improve preventative, risk-assessment and management practices. We have also appointed a dedicated Tissue Viability Practitioner and supported that role with a dietitian, medical photographer and podiatrist.

During 2012/13 we started to pilot **SSKIN** across selected wards; this is a five step model for pressure ulcer prevention and treatment which includes,

- **S**urface: making sure our patients have the right preventative support,
- **S**kin inspection: early inspection means early detection,
- **K**eep patients moving,
- **I**ncontinence / moisture: making sure patients are always clean and dry,
- **N**utrition / hydration: helping patients to have the right diet and plenty of fluids

Once we have evaluated SSKIN on these pilot wards, we plan to roll out to other wards throughout 2013.

Focusing on patient experience

a) The NHS National Patient Survey programme

The NHS national patient survey programme is part of the government's commitment to ensure that patient feedback is obtained so that it can be used to inform the continued development and improvement of healthcare services. Each trust is legally obliged to carry out a survey of patients' views on their recent healthcare experiences. Feedback from these surveys allows organisations to compare their results and helps us to identify where we have performed well and highlights gaps in our services which we can improve.

For 2012/13 City Hospitals participated in the following national patient surveys;

Type of survey	Data collection	Expected month of publication	Notes
Accident and Emergency departments	May – Aug 2012	Dec 2012	Published
Survey of adult inpatients	Sept 2012 – Jan 2013	April 2013	Published
Cancer experience survey	Jan – April 2013	July 2013	Survey in progress
Chemotherapy survey	Jan – April 2013	July 2013	Survey in progress

In 2013/14 the Trust will take part in the following national surveys;

- Maternity Services survey (May – August 2013)
- Emergency and elective inpatients (September 2013 – January 2014)

i) Survey of adult inpatients (2012)

The national survey of adult inpatients (2012) provides an opportunity for patients to give their views on the service they have received from City Hospitals. It remains one of the largest surveys of patient experience in hospital of its kind. The questionnaire asks patients to comment on topics ranging from hospital food, cleanliness, privacy and dignity, to communication with staff, discharge planning and their overall hospital experience. Questionnaires were posted to 850 people, in line with the national sampling strategy, and 467 were returned complete, giving a response rate of 56% (the national rate was 51%).

The results show that across the 60 questions which measure our performance from the patient's perspective, 58 (97%) are in the amber 'expected range' category, meaning that we are about the same as most other Trusts in the survey. There were no questions and scores in the green category rated as the best performing Trusts.

However, we did have 2 questions in the red or 'worst' performing category. It is disappointing to report that these two questions relate to choice of food and the patients perception of our management of their pain. Last year, our results for both questions moved the Trust into the 'amber' category and we believed we were heading in the right direction. These latest results suggest that we still have much more to do. The respective working groups will reflect on these results and re-evaluate their efforts to bring about the improvements needed.

The 'section' table highlighted below provides an aggregated score for questions grouped according to the sections in the inpatient questionnaire. A higher score is better. Each Trust is also assigned a category, to identify whether their score is 'better', 'about the same', or 'worse' than most other Trusts who carried out the survey. City Hospitals achieved an 'about the same' rating for each of the 10 sections compared with other Trusts.

Score	Section themes	Rating compared with other Trusts
8.4/10	The Emergency Department / A&E Department	WORSE / ABOUT THE SAME / BETTER
9.1/10	Waiting list and planned admissions	WORSE / ABOUT THE SAME / BETTER
7.8/10	Waiting to get to bed on a ward	WORSE / ABOUT THE SAME / BETTER
8.0/10	The hospital and ward	WORSE / ABOUT THE SAME / BETTER
8.6/10	Doctors	WORSE / ABOUT THE SAME / BETTER
8.2/10	Nurses	WORSE / ABOUT THE SAME / BETTER
7.5/10	Care and treatment	WORSE / ABOUT THE SAME / BETTER
8.3/10	Operations and procedures	WORSE / ABOUT THE SAME / BETTER
7.3/10	Leaving hospital	WORSE / ABOUT THE SAME / BETTER
4.9/10	Overall views and experiences	WORSE / ABOUT THE SAME / BETTER

The tables below show where the Trust has achieved the largest increase and decrease in scores for individual questions compared to the last survey in 2011.

Survey questions – comparison of 2011 and 2012 results		2011	2012	2012
Questions where we have increased our scores the most (higher score is better)				
Q7	Was your admission date changed by the hospital?	9.2	9.5	↑
Q26	Did doctors talk in front of you as if you weren't there?	8.4	8.7	↑
Q61	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.7	6.0	↑
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	6.5	6.8	↑

Survey questions – comparison of 2011 and 2011 results		2011	2012	2012
Questions where we have the greatest 'loss' in scores, i.e. worse than the last survey				
Q23	Did you get enough help from staff to eat your meals?	7.7	6.7	↓
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.6	7.8	↓
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.4	7.8	↓
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	6.4	5.8	↓
Q39	Do you think the hospital staff did everything they could to help control your pain?	8.1	7.5	↓

The Patient, Carer and Public Experience Committee (PCPEC) will ensure that an action plan is agreed to address the issues within the latest inpatient survey results. Updates to the action plan will be presented quarterly to PCPEC and also shared with the Sunderland Clinical Commissioning Group as part of our information exchange and assurance with Commissioners.

ii) Accident and Emergency Department Survey 2012

In December 2012, the Care Quality Commission published the national and individual Trust results for the fourth Accident & Emergency Department Survey. Nationally, almost 46,000 patients aged 16 or older from 147 NHS Trusts in England completed questionnaires. The survey involved a sample of patients who attended A&E in February 2012 and for City Hospitals the response rate of 45% (372 patients) was much better than the national average of 38%.

The survey assesses a number of different aspects of people's experiences (such as care received from doctors and nurses, tests, views on the hospital environment e.g. cleanliness) and is scored according to each individual question and section category. Out of the 8 section categories the Trust has achieved an 'about the same' rating which means that the Trust is about the same as most other Trusts who took part in the survey. Out of 37 questions measuring Accident & Emergency Department performance, the Trust achieved 36 scores in the amber category and an 'about the same' rating (as most other hospitals), and 1 score in the green section indicating a 'better' rating (better than most other hospitals). There were no scores in the red, 'worse' category.

The results of the survey have been presented to the Patient, Carer and Public Experience Committee and the Board of Governors. They have also been shared with clinical and management teams within Accident & Emergency and an action plan has been developed to address any shortcomings.

What did our patients say about their experience in Accident & Emergency?

The questionnaire gave patients the opportunity to add any further comments about their experience of the Accident & Emergency Department. These comments are reported verbatim and some brief examples (positive and negative) are highlighted below;

The treatment I received from all concerned was the best I could have received. I could not have received better treatment at a private clinic

Staff chatted amongst themselves at a desk and ignored myself and other patients

Very thorough examination, tests, diagnosis and treatment

Yes, nurses should believe what patients tell them and not jump to their own conclusions.

I left feeling quite cheerful although in pain as the doctor went just that extra mile for me. She was a tonic in herself, very pleasant and understanding, a credit to the health service.

Waiting times can be horrific when you are feeling ill and weak. It makes you feel worse.

I was treated with great care and respect all the time in A+E and also in hospital when I was admitted until I was discharged.

The triage staff need to be more empathetic. I wasn't told why it had happened or what to do next or anything.

All the staff had a caring attitude, particularly the doctor who kept me informed repeatedly during my distressing stay in A+E. All tests were carried out in a concerned and caring manner. I could not have received better care elsewhere.

I have no hearing at all but, no one took the time to write things down

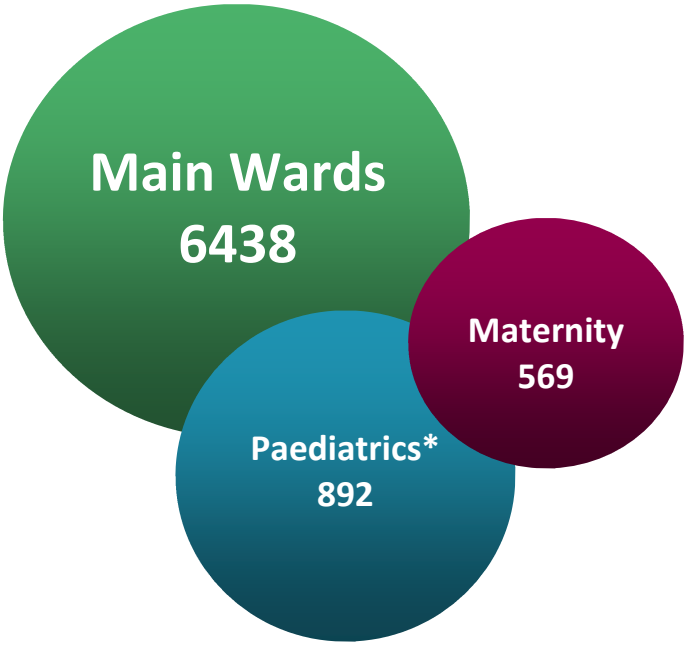
The receptionist was very patient and understanding

Waiting area cramped and uncomfortable

The doctor who attended to me was excellent. They thoroughly examined me and listened intently as I explained my symptoms. The staff were most cheerful, considerate, helpful and caring

b) Real Time Feedback

Our local real time feedback programme complements the annual national patient surveys and provides a continuous way of collecting and capturing the views of patients as they prepare to be discharged from hospital. The information is collected by our volunteers.

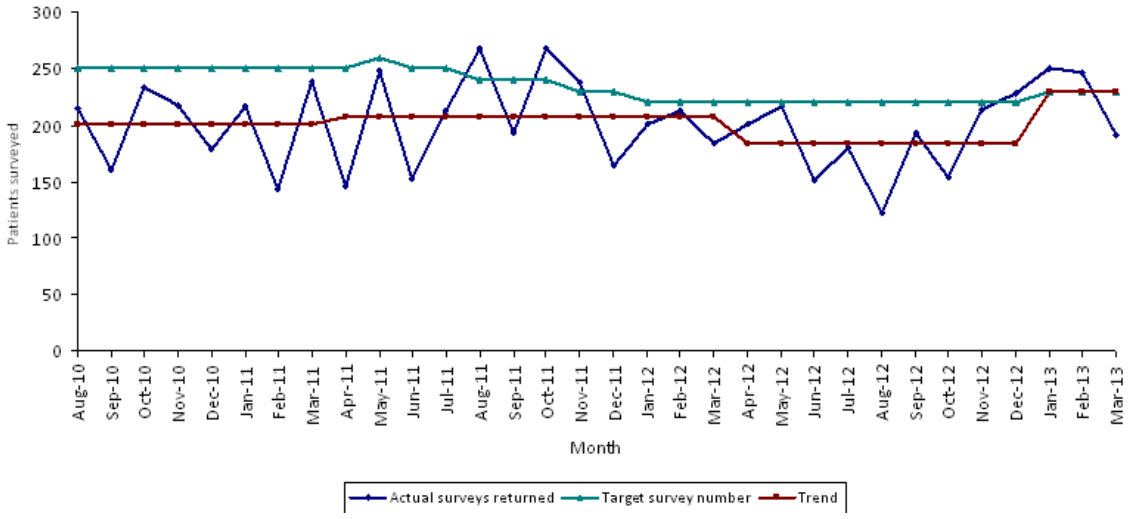


We introduced this new method in August 2010 across the majority of our inpatient wards and over time we have expanded the collection to include our maternity and paediatric wards and the Integrated Critical Care Unit (ICCU).

The graphic opposite shows the total number of completed patient questionnaires to date (August 2010 – Feb 2013). This excludes the ICCU which has received 155 responses. Many of the questionnaires have additional comments which provide valuable information about the patient experience and what matters most to patients.

* includes questionnaires from children (366) and parents (526)

The table below shows the total number of collected and analysed surveys per month since the start of real time feedback in August 2010. An adjustment has been made to the target threshold of completed surveys in view of the ongoing reconfiguration of wards and its effect on the total number of returns expected. During the year there have been occasions where our volunteers have not been able to collect the minimum number of questionnaires per ward. High patient participation is an important part of our real time feedback system.



A schedule of meetings between the Head of Nursing & Patient Experience, the Volunteers Coordinator and Clinical Governance has explored ways to maximise volunteer involvement in real time feedback. As a consequence, our performance in Q3 and Q4 has shown an encouraging upward trend in patient participation.

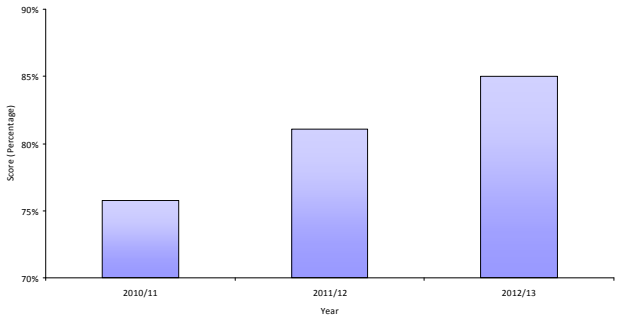
Where are we doing well?

Last year we highlighted areas where we had the highest range of aggregated (average) scores; we have done even better during 2012/13 as the table below illustrates;

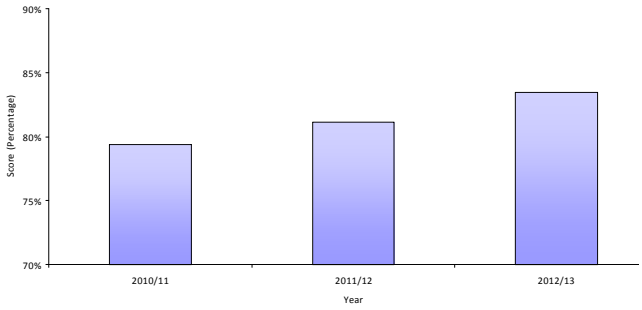
Top scoring questions of 2011/12		2011/12	2012/13	Change
B1	When you were first admitted to a bed on this ward, have you ever had to share a sleeping area, for example a room or bay, with patients of the opposite sex?	95%	97%	↑
C1	Are you treated with privacy, dignity and respect?	95%	96%	↑
C4	Have the staff been polite and professional during your stay?	96%	96%	⇔
C5	Is the ward clean and tidy?	96%	96%	⇔
C6	Do you have somewhere to keep your personal belongings whilst in hospital?	99%	99%	⇔
C7	Do staff wash or clean their hands before providing your care?	97%	97%	⇔

For some questions within real time feedback we are able to show incremental improvement in scores year by year (from Aug 2010 to Feb 2013), as the following charts show;

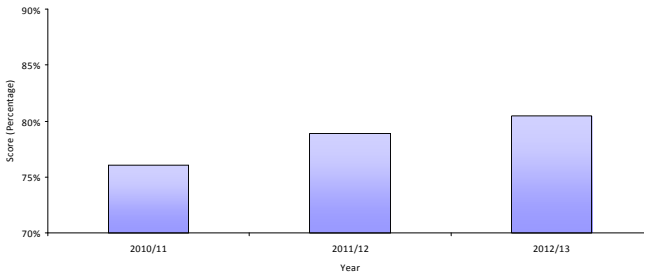
C10 Do staff inform you about medication side effects?



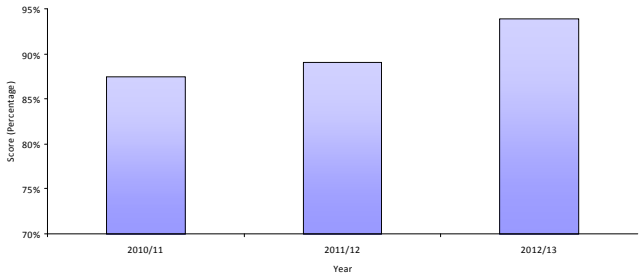
C11 Is your food well presented and hot enough?



C12 are you offered a good choice of food?



C15 Have you been told about who to contact if worried about discharge?



What improvements have we made?

Simply collecting feedback from patients in itself has no value. It needs to be used by hospital staff to identify where improvements are needed. This is one of the more challenging aspects of collecting patient feedback but one which is crucial in showing to patients that we are genuinely listening and that their experience matters. The following examples highlight where wards have reflected and acted on the results of their patient feedback;

- Bariatric (obese) patients now have continental breakfast served at 7am in support of their dietary regimes (instead of a cooked breakfast),

- Pharmacy staff have been involved in discussing side effects of new medication with patients,
- Introduction of a specific 'doctors book' to ensure messages are passed on and logged to help improve communication within the clinical team,
- There is a specific menu available on the Integrated Critical Care Unit (ICCU). The choice of meals has been expanded to include a hot option at lunchtime, and
- We now ensure that our patients are made aware of the Critical Care Outreach Team when they are transferred out from ICCU onto base wards. The ICCU nurse informs them of this and it has now been included in the Unit's patient information booklet.

What has changed from patient feedback in Maternity Services?

The maternity questionnaire is slightly different to the main design used across the inpatient wards in that it is more relevant and useful for the mothers (and their partners who are also invited to participate). From within maternity services, the following changes have been made to practice;

- Fathers expressed a wish to stay with their wives/partners following the birth of their baby. The Directorate acquired recliner chairs and now offer fathers an overnight stay for the first night post delivery. This has been well received and has produced positive comments. We are now in the process of purchasing additional recliner chairs which convert to a bed to offer more comfort to partners,
- Following delivery of their baby, women were often hungry and had to wait until set mealtimes or did not want meals offered. The Directorate acquired a toaster to enable women to have tea and toast outside of set mealtimes,
- We encourage use of the 'lite bite' service for out of hours' deliveries/admissions. We have installed vending machines with drinks/snacks for patient use in Delivery Suite and the Antenatal Clinic, and
- Progress is being made with our water birth facility in the maternity unit which should be up and running by June 2013; this will enable more women to have a relaxing birth in a safe environment.

What has changed from patient feedback in Paediatrics?

A different model of real time feedback is used in the paediatric wards. Again this reflects the need to customise the survey for our younger patients. In addition, we also include the child's parents or carer's views and that has proved very useful in helping the paediatric team to identify areas of improvement. The paediatric wards have been able to make a number of changes to their practice, which include:

- Paediatric staff now ensure that pain scores are recorded regularly and inform children of what effect analgesics will have,
- Trial of take-away lunch boxes for children on the Paediatric Wards,
- Nursery nurses provide play sessions/toys for each child and we have provided more toys for the play room, e.g. dressing up clothes (small firemen, super heroes and princesses are seen regularly within the ward environment),
- Improved the awareness of real time feedback results to ward staff by inclusion at ward meetings to raise parents'/childrens' perception of care, and
- Alterations have been made to the Treatment Room and the Multi Purpose Room (in the Niall Quinn Outpatients Centre) to enhance children's (and parents') privacy and dignity, e.g. moving cupboards, curtain rails etc.

What has changed in response to patient feedback in the Integrated Critical Care Unit (ICCU)?

- Patients reported reduced periods of sleep due to the lighting and noise within ICCU. Following this, estates are in the process of fitting dimmer switches to the lighting. The ICCU co-ordinators

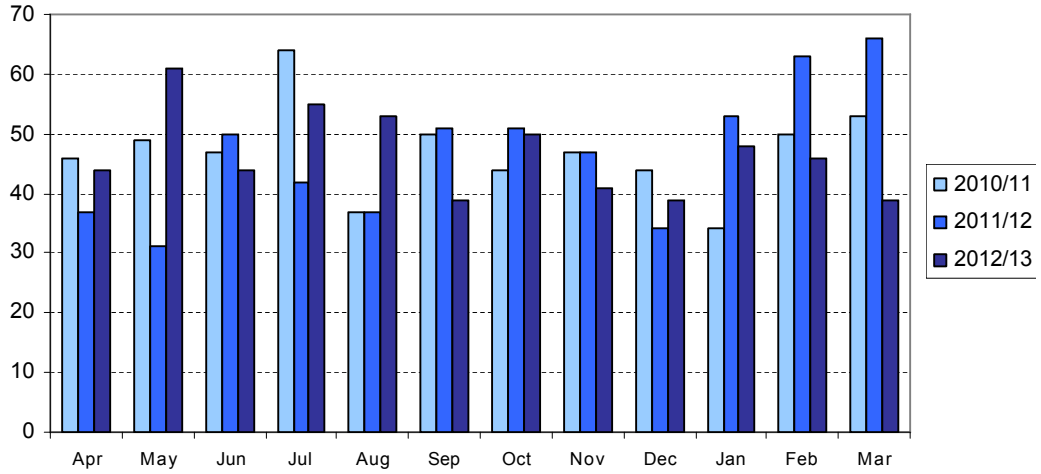
are also actively encouraging a reduction in noise levels within the Unit and monitoring noise levels accordingly.

c) Listening to patients – learning from our complaints

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

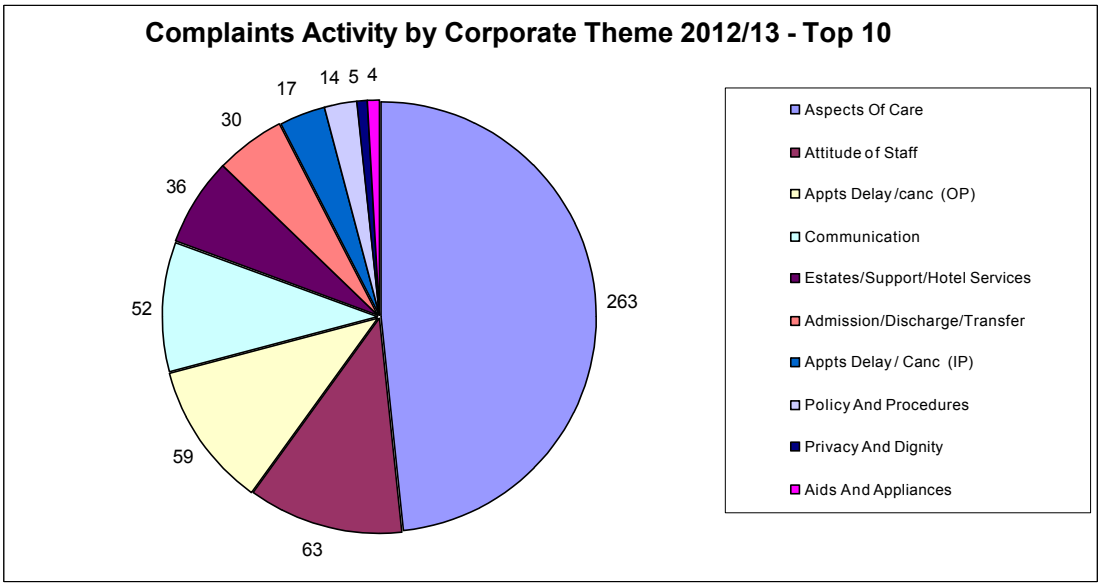
During 2012/13 the Trust received 559 formal complaints from patients or their representatives, a slight decrease on the 562 received last year. This number differs from that reported in last year's Quality Report (534), as in 2012/13 a data cleansing exercise has been undertaken. In addition, complaints monitoring is a dynamic process and informal complaints can escalate to formal complaints over time, impacting on the year end figure. The chart below shows the distribution of complaints received each month for the current and previous years.

Comparison of complaints activity 2010/11 to 2012/13



The chart below shows that the most common themes from complaints received by the Trust were related to aspects of clinical care and treatment, attitude and behaviour of staff, and communication and appointments.

Complaints activity by theme 2012/13



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

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

- A number of improvements in relation to car parking have included improved signage in disabled parking bays, information added to patient appointment letters, additional information regarding parking placed in all waiting areas, additional car parking machines and information displayed to ensure visitors are aware they can purchase a £10 monthly parking permit,
- Providing a meet and greet service for patients in the Main Outpatients' Department (as a result of concerns made by carers),
- Using patient stories in staff training sessions such as discharge training, raising awareness of carers and customer care,
- Implementation of a new procedure for the management of patients soiled clothing,
- A whole system review of scheduling new and review out patient appointments to reduce the number of appointment letters being sent to patients, reminding people about their appointments, and minimising the impact of any internal rescheduling on patients,
- A new way of working has been introduced that increases senior doctor cover on the Acute Medical Unit (AMU) between 0600 and 2200 hours, to eliminate the long waits to see a doctor,
- Giving patients access to see the bariatric specialist nurses at short notice to support patients with acute symptoms following surgery,
- Alerts have been put onto the HISS (current hospital information system) "bulletin board" of individual patient's electronic records as a way of cascading key clinical information for doctors and nurses using the system, and
- The way consent forms are used has been reviewed to ensure that risks specific to individual patients as a result of underlying conditions are clearly highlighted during the consent process. A written copy of the risks is provided to patients to enable them to fully digest the information prior to the procedure taking place.

d) Ward Assurance Visits

During 2012/13 a programme of ward visits was undertaken to seek assurance on issues such as patient safety and the experience of patients by a team which included the;

- Executive Director of Nursing and Quality;
- Non Executive Director of City Hospitals;
- Lead Matron for Quality Improvement;
- Representatives from Estates and Facilities; and
- Non Executive Director from the Primary Care Trust.

The scope of the visits included an environmental inspection as well as talking to patients and staff about their experiences. Once completed, immediate feedback was provided to the nurse in charge. The outcomes from each visit were also shared with the Matron, to ensure any necessary action was carried out. A number of interventions have been undertaken as a result of this process which have included the replacement of drug fridges, making changes to cleaning schedules and prioritising areas for decoration and refurbishment.

e) Patient Advice and Liaison Service (PALS)

A review of the PALS and Complaints Department was undertaken in March 2013 with a number of actions being identified to improve the current process and provide a more individualised and timely response for patients and their families.

f) Volunteers

Volunteers provide a valuable service that involves spending time, unpaid, to support Trust staff in delivering a quality service. Their role is to complement the work of paid staff and they are therefore not included in staffing numbers. All volunteers undergo a series of pre employment checks and are subject to an interview. We have 452 volunteers registered in the Trust who undertake a variety of roles which include; assisting with administration, befriending patients, meeting and greeting visitors, supporting clinical staff at meal times, answering the telephone and collecting feedback from patients.

g) Carers

City Hospitals Sunderland works alongside staff at the Sunderland Carers' Centre to improve the experience of the many patients and carers who use the facilities. In June 2012 we launched our Carers Charter stating our intention to value the carer as the expert in care delivery for their loved ones as well as working in partnership with the carer and family when discharge planning to ensure continuity of care and prevent any breakdown in the carer role.

A Carers Reference Group meets quarterly to discuss issues raised by carers. The meetings have had a positive impact here at Sunderland Royal Hospital. Carers told us that patients with disabilities and their carers would benefit from some additional assistance when they come to hospital for outpatient appointments, investigations or visiting. With prior notice, carers can 'drop off' at the entrance before parking the car, and we can arrange for a volunteer to stay with the person or accompany them to their destination.

During 2012 staff from the Carers' Centre have been involved in providing training which has proved an excellent opportunity for staff from the Trust to gain first hand experience of the role of a carer. This has generated valuable discussion and our commitment to carers has continued by inviting the Carer's Centre to join our recruitment panels for staff nurses.

Sunderland Multi Agency Carers Strategy 2012 – 2015 was published in December 2012. The Strategy reiterates Sunderland's commitment to carers and provides a broad outline of what it will achieve to improve the lives of carers in line with the National Carers Strategy. The Strategy identifies 6 strategic objectives and identifies high level actions for achieving each objective. The Trust in partnership with the Carers' Centre has translated these into an action plan to ensure delivery against the strategic objectives.

The Standing Commission on Carers visited Sunderland in September 2012, as part of a number of 'fact finding' visits nationally to explore how the NHS Operating Framework requirements on carer support were being carried forward in partnership with the local authority and the voluntary sector. The Commission reported that they were particularly impressed by what they saw and heard in Sunderland, especially the proactive and strategic partnerships between the NHS and the local authority and voluntary sector.

h) Community Panel

Following the 10th anniversary of the Community Panel and the strengthening of their role within our patient and public involvement work, we can report further examples of their activities;

- Leading the feedback collection from patients on wards who participate in Real Time Feedback,
- For the 9th year running helping with the Patient Environment Action Team (PEAT) inspections and making sure that the process is objective, fair and accurate,
- Undertaking a Trust-wide survey of the access and patients' understanding of the 'Your Stay in Hospital' bedside folder and making recommendations to improve accessibility as part of the admissions process,
- Taking part in a pilot of the DH Human Rights in Healthcare Project, testing out with patients the questionnaire expected to be rolled out to other hospitals,
- Carrying out a repeat Trust-wide audit of patient identity bracelets (wristbands) to coincide with national Safer Surgery Week (September 2012),
- Participating in the Pain Standards of Care Event held on the 18th June 2012,
- One of our Panel members played the acting role of a 'surgical patient' in the production of a joint patient safety initiative video (City Hospital Sunderland/Northumbria Healthcare Trust). The video will provide important safety messages for patients involvement in healthcare safety,
- Attending the Deaf and Blind Awareness Conference in May 2012, and
- Ongoing, active contributions to a number of Trust working groups and committees.

i) Patient Environment Action Team (PEAT) inspections

Last year we reported that City Hospitals (Sunderland Royal Hospital and Sunderland Eye Infirmary) had achieved the highest level of rating (*Excellent*) in the 2011 PEAT inspections. This is an annual self-assessment which measures standards across a range of services including food, cleanliness, infection control and aspects of the patient environment (including bathroom areas, décor, lighting, floors and patient areas). The PEAT exercise has for a number of years involved Trust Governor Representatives and members of our Community Panel, in addition to senior nursing, catering and facilities staff.

From April 2013 the existing national PEAT programme will be replaced by a new inspection regime, to be known as Patient-Led Assessment of the Care Environment (PLACE). The focus of the revised process will continue to be cleanliness, buildings/facilities, privacy and dignity and food but there will be a number of changes to the details of the assessment, the scoring methods and the number of and responsibilities of the patient representatives. The preparation and transition to the new national PLACE assessment has meant that the Trust did not have a formal PEAT inspection in 2012. Our first PLACE assessment will take place later in 2013.

Whilst PEAT (and the new PLACE) is an annual requirement, the Trust has in place more regular, routine systems for monitoring aspects of both the clinical and non-clinical environment, which include;

- Monthly multi disciplinary National Standards of Cleanliness Group whose terms of reference include a review of daily monitoring results and follow up action plans,
- Monthly Domestic Contract Review Group to assess the contract performance so that it aligns with the Trust Cleaning strategy,
- Monthly Strategic Infection Control Group where a cleaning & environment report is a standing agenda item,
- 2-weekly cleaning and monitoring operational meetings with local managers to follow up progress on all agreed actions,
- Daily monitoring following a cleanliness audit process across the organisation as directed by national documents,

- Ward Quality Assurance visits are carried out fortnightly by the Executive Director of Nursing & Quality, Non-Executive Director, Matron for Quality Improvement, and Estates and Facilities representatives, and
- Daily cleanliness standards reports with associated actions.

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

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

In 2012/13 we had a breach of mixed sex sleeping accommodation on Chest Pain Assessment Unit (CPAU) during June 2012 which affected 4 patients in a bay on the ward for approximately 20 hours. The initial patient remained on CPAU for more than 4 hours after being diagnosed as 'non cardiac'. A full root cause analysis was undertaken and several quality improvement actions were identified, particularly around the escalation process should a similar situation occur again in the future.

Actions in 2012/13

During 2012/13 CHS worked in partnership with Northumbria University to develop Dignity, Privacy and Respect Master Classes. The programme was designed to enable any member of staff from CHS to attend. The Master Class was well attended by both clinical and non clinical staff. Participants developed and implemented individual action plans in their own areas of expertise and practice which effected small but significant changes in an effort to improve patient experience. Some examples of changes in practice/implementation include:

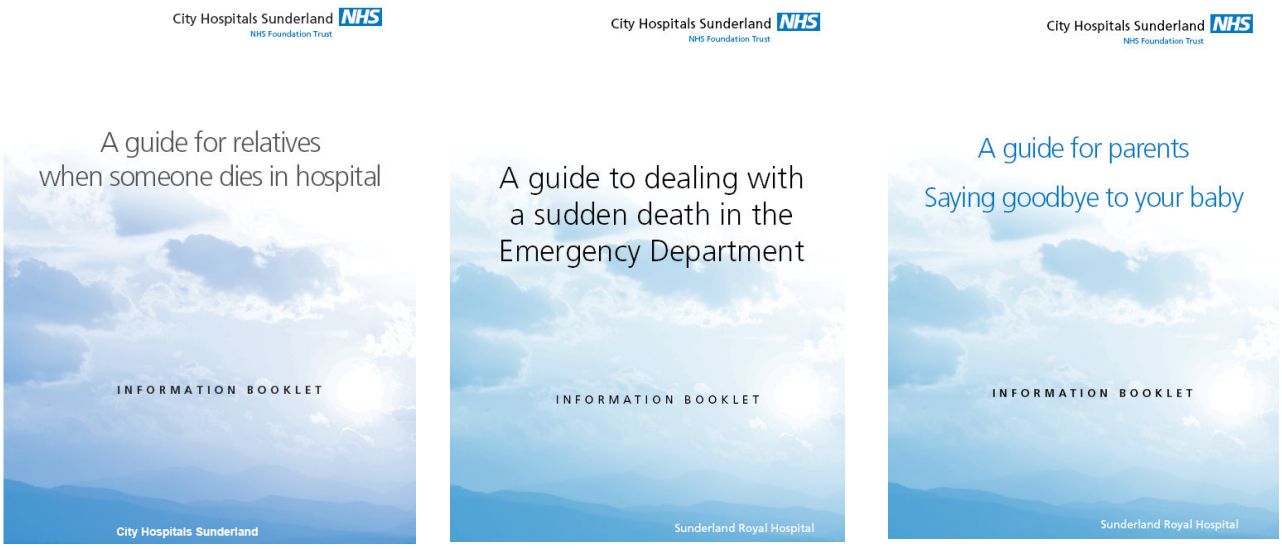
- Endoscopy Unit: “dignity pants” offered to patients undergoing intimate and embarrassing procedures,
- Chester Wing Outpatients Department: mobile screens to prevent exposure for patients/visitors who unexpectedly collapse in public areas of the Trust,
- Sunderland Eye Infirmary main operating theatres: designated area for wheelchair users appropriate to their needs while waiting commencement of surgical procedures, and
- Sunderland Royal Hospital main theatres: use of small foam pouches to enable patients to wear and safely store spectacles while in the Anaesthetic Room.

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

In April 2012, Internal Audit noted that the Trust had made significant progress against the action plan to eliminate mixed sex accommodation and was able to give significant assurance that controls are applied consistently. As a result of this report, and the breach in June 2012 further actions have been identified to improve the patient experience and these have been included in an action plan, which is monitored by the Patient, Carer and Public Experience Committee.

k) Improving information for patients during bereavement

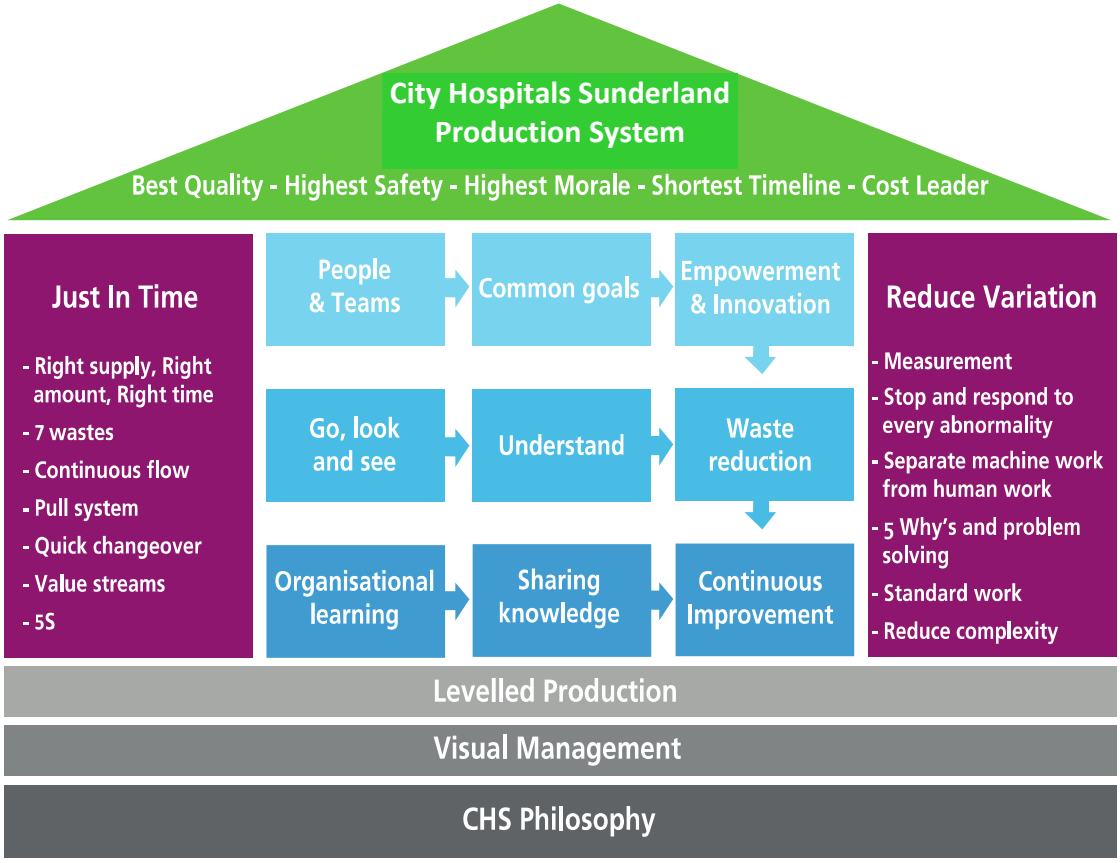
Throughout 2012/13 we have taken the opportunity to update, revise and re-launch our information guides for families who have experienced loss and bereavement.



l) Improving quality using a *Lean* philosophy

Building *Lean* business systems and processes, we can ensure that our energy and resources concentrate on value from the patient's perspective. With a focus on delivering our vision of *Excellence in Health* we identify the waste or non value adding activities in our systems and processes and do all that we can to remove them, freeing up more of our clinical and administrative time to do the things that matter most to patients.

The CHS Production System is our interpretation of *Lean* philosophy and our approach to continuously improving and striving to deliver safe care, effective care and a first class patient experience.



The Kaizen Promotion Office provides continuous improvement facilitation to a number of projects across the organisation. Some of these include:

Appointment Scheduling

In the past, patients were receiving appointment letters at the time of scheduling. This often led to multiple letters informing patients of changes to their scheduled appointment, particularly when the appointment is several months in advance. This sometimes caused confusion with patients turning up on the wrong day or not at all. It also wasted Trust resources.

Now, the appointment date and time is confirmed with the patient, by letter, about a month before the appointment takes place. Patients do not receive a letter about their appointment at the time it is scheduled, unless it occurs in the coming weeks.

Appointment Reminder Service

In the last 12 months more than 38,000 patients failed to attend their outpatient appointment at CHS without giving any prior notice. CHS has been piloting an outpatient reminder service. So far, this has been successful for both the hospital and our patients. For patients receiving the service, figures show a 33% reduction in the number of patients who do not attend their appointments. Patients are given the option to cancel and rearrange through the reminder system. This means the Trust can reallocate appointments for other patients. This not only reduces patient waiting times but also ensures we use our resources more effectively. Recently, the service has been extended and is now sending out nearly 15,000 reminders per month.

Emergency Care Pathway – Minor Illness and Injury

The Trust aim is that patients arriving at the Emergency Department (ED), with minor illness and injury, receive the right assessment and treatment, by the right clinician, first time, every time. For this improvement a Rapid Process Improvement Workshop (RPIW) was undertaken involving 10 members of the ED team to develop the new process.

Working closely together, the receptionist and navigation nurse now ensure that vital clinical history and personal details are captured at the first point of contact. Patients requiring urgent assessment and treatment are identified within the first 60 seconds of arrival and patients attending the ED with minor complaints are seen, managed and educated regarding alternative services appropriate to their needs. The creation of the 'See & Manage' concept enables patients with conditions that require no diagnostic investigations, e.g. X-Ray & blood tests, to be managed quickly by an Emergency Nurse Practitioner, GP or ED doctor.

Improving the pathway for patients with Hip Fractures

Hip fracture is a major public health issue due to an ever increasing ageing population. About 10% of people with a hip fracture are at increased risk of mortality. The falls and fracture often signal underlying ill health, so that a comprehensive multidisciplinary approach is required from presentation to subsequent follow-up.

The project aim was to reduce the waiting time from diagnosis of a hip fracture within A&E to surgery taking place within 36 hours. Before the improvement this was an average of 47 hours. A workshop was undertaken involving 12 members of the multi-disciplinary team involved in the care of patients with hip fracture from arrival at A&E to discharge from hospital.

The waiting time of 36 hours is now met 90% of the time (previously 60%). The average length of stay has been reduced by 2 days for this group of patients. This project was short listed for a national award at the 'Lean Healthcare Academy Awards 2013', in the category: "Best Impact on Patient Experience".

Radiology: World Class Diagnostics

A programme of work using Rapid Process Improvement Workshops and other CHS Production System techniques has led to further improvements throughout Radiology services.

Voice recognition technology and improvement to work processes has seen further reductions in the time taken from a patient being referred to CHS for an x-ray and the results being reported back to their GP, so that appropriate clinical management can progress.

Recent pilot work with the portering service to improve the flow of inpatients into and out of the department has demonstrated improvements. These include reduced delays for inpatients' scans and increased utilisation of scan rooms. Capacity and demand work is being undertaken to ensure that the department has the necessary allocation of porters to enable these enhancements to patient experience and resource efficiency to be maintained.

The outpatient ultrasound process has been improved to provide streamlined procedures prior to scans taking place. Ultrasound referral to scan time has been reduced from nearly 6 weeks to 3 weeks.

The Phoenix Unit

A new Unit for patients receiving Oncology and Haematology services opened officially in February 2013. The Phoenix Unit is a nurse led unit, providing integrated care to patients receiving Chemotherapy and other supportive therapies. Development of the new service involved the coming together and relocation of Oncology and Haematology services. Existing processes were reviewed and improved using *Lean* tools and techniques. Unnecessary steps and delays for the patients have been removed from the process. In particular the way in which patients are met and welcomed into the department has significantly improved. New roles and responsibilities for administrative staff have improved patients' experience and enabled nurses to spend more time delivering expert healthcare.

Part 3C Performance against key national priorities 2012/13

Performance against National Measures

During 2012/13 the Trust has continued to maintain national operating standards across a number of key measures including cancer waiting times, referral to treatment and diagnostic waits (including incomplete pathways), A&E total time and risk assessment for hospital-related venous thromboembolism (VTE)

The NHS Operating Framework 2012/13 aimed to limit the key performance measures that would be subject to national assessment in order to support more local decision making on priorities. The table below highlights the National Performance Measures, many of which are also assessed as part of Monitor's Compliance Framework. Monitor, the regulator of Foundation Trusts produced a 'Governance' risk rating for each organisation at the end of 2012/13; City Hospitals was rated Amber Green.

Indicator	Last Year 2011/12	Target 2012/13	YTD 2012/13	YTD Variance	YTD
Quality (Safety, Effectiveness & Patient Safety)					
HCAI measure (MRSA)[1]	1	<1	6	5	●
HCAI measure (CDI)[1]	64	<44	60	16	●
Referral to Treatment waits % completed admitted pathways seen within 18 weeks	95.61%	90%	94.39%	4.39%	●
Referral to Treatment waits % completed non admitted pathways seen within 18 weeks	98.70%	95%	99.09%	4.09%	●
Referral to Treatment waits % incomplete pathways waiting less than 18 weeks	90.10%	92%	95.35%	3.35%	●
Diagnostic Test waiting times[2]	0.77%	1%	0.27%	-0.73%	●
A&E waiting time - Total Time in the A&E Department	95.49%	95%	95.08%	0.08%	●
All Cancer Two Week Wait[3]	94.12%	93%	94.98%	1.98%	●
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)[3]	96.14%	93%	94.77%	1.77%	●
All Cancer 62 day urgent referral to treatment wait[3]	89.08%	85%	89.00%	4.00%	●
62 day wait for first treatment following referral from an NHS Cancer Screening Service[3]	95.83%	90%	94.23%	4.23%	●
31 day standard for cancer diagnosis to first definitive treatment[3]	99.31%	96%	99.58%	3.58%	●
31 day standard for subsequent cancer treatments - surgery[3]	99.28%	94%	100.00%	6.00%	●
31 day standard for subsequent cancer treatments - anti cancer drug regimens[3]	100.00%	98%	100.00%	2.00%	●
MSSA breaches	3	0	4	4	●
VTE risk assessment for inpatient admissions	92.13%	90%	92.36%	2.36%	●
Quality stroke care - people who have a stroke who spend at least 90% of their time in hospital on a stroke	85.05%	80%	88.06%	8.06%	●

unit					
Quality stroke care - people at high risk of stroke who experience a TIA are assessed and treated within 24 hours	60.85%	60%	63.56%	3.56%	●

[1] Cases apportioned to Acute Trust

[2] New indicator from the Operating Framework 2012/13

[3] Year to date position including un-finalised performance for March

Cancer 62 day urgent referral to treatment wait

This indicator has been subject to limited assurance from our external auditors as mandated by Monitor. The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to below;

- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer,
- An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant,
- The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait);
- The clock start date is defined as the date that the referral is *received* by the Trust, and
- The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Clostridium difficile infection

This indicator has also been subject to limited assurance from our external auditors as mandated by Monitor. The assessment criteria are highlighted below;

- a *C. difficile* infection is defined as a case where the patient shows clinical symptoms of *C. difficile* infection, and using the local Trust *C. difficile infections diagnostic algorithm (in line with DH guidance)* is assessed as a positive case,
- positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken, and
- acute provider Trusts are accountable for all cases of *C. difficile* infection for which the Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that Trust (where the day of admission is day one).

Healthcare Associated Infection

The Trust has failed to achieve the nationally set targets specific to City Hospitals for both MRSA bacteraemia cases and *Clostridium difficile* infections during 2012/13. Due to the significant progress the Trust made in 2010/11 to reduce the number *Clostridium difficile* infections, the prescribed target in 2011/12 was more than halved from less than 98 cases in 2010/11 to less than 44 in 2011/12. Whilst the target remained the same in 2012/13 at less than 44 cases, it has once again proved to be very challenging despite a continued focus and commitment on reducing healthcare associated infections. In terms of MRSA, the Trust has had more cases in 2012/13 compared to 2011/12, increasing from just 1 case to 6

cases, respectively, against an extremely challenging target of just one case for the entire year. Further information on both these targets can be found within Part 2A of the Quality Report.

Referral to Treatment Waits

The NHS Constitution sets out patients' rights to access services within the 18 week maximum wait from referral to treatment (RTT). The national RTT indicators were refocused in 2012/13 on not only the percentage of admitted and non admitted patients treated within 18 weeks of their initial referral, but there has also been a national standard implemented for the proportion of patients currently waiting less than 18 weeks for their treatment (incomplete pathways). The Trust has consistently achieved the operational standards throughout 2012/13. Performance for admitted waits has been has been 94.5% on average against a 90% target, non admitted waits has been 99.1% on average against a 95% target and incomplete waits has been 95.5% on average against a 92% target. The Trust is confident that the RTT operational standards will continue to be maintained throughout 2013/14.

Accident & Emergency (A&E)

During 2012/13 the Trust experienced significant operational pressures that affected the A&E department, not only over the usual winter period but also throughout the spring and summer, with a higher volume of A&E attendances observed during these periods compared to previous years. This also led to an increased number of patients that were admitted to hospital from A&E and during the winter period with a high proportion of patients attending with complex clinical conditions and an unusually high number of patients affected by D&V (diarrhoea and vomiting) and the norovirus. Despite these severe pressures, the whole organisation has contributed towards delivery of the national operating standard of 95% of patients spending less than 4 hours in the department and as a result of this commitment the Trust has been able to achieve the target. During 2013/14 we will continue to work with partner organisations such as GP practices, North East Ambulance Service, Community and Social Services to ensure Sunderland has an integrated service for patients with urgent and emergency needs. For example, one of the improvement goals that forms part of the Trust's CQUIN scheme for 2013/14 is focused on a multi-agency approach to reducing ambulance handover times as well as other initiatives to improve the service for patients attending A&E.

Venous-Thromboembolism (VTE) Risk Assessments

The Trust has consistently achieved the 90% target throughout 2012/13 for VTE risk assessments, which is also a mandatory element of the Commissioning for Quality and Innovation (CQUIN) framework. The Trust has also continued to maintain high standards against the additional VTE quality indicators included in the Trust's CQUIN scheme for 2012/13, which includes offering VTE prophylaxis in accordance with NICE guidance to patients assessed to be at increased risk of VTE as well offering patients and carers verbal and written information on VTE prevention as part of the admission process. CQUIN enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of national and local quality improvement goals.

Stroke

The Trust has continued to achieve and improve against targets relating to the care of stroke patients, which includes the percentage of patients that spend more than 90% of their time in hospital on a stroke unit and people at high risk of Stroke who experience a TIA being assessed and treated within 24 hours. In 2012/13 88.06% of stroke patients spent more than 90% of their time in hospital on the stroke unit, which represents an improvement from 2011/12 at 85.05% and is also above the national target of 80%. Similarly, the proportion of people at high risk of Stroke who experienced a TIA and were assessed and treated within 24 hours has increased from 60.85% in 2011/12 to 63.56% in 2012/13, against a target of 60%. Delivery of high quality stroke services is also included in our CQUIN framework which takes into consideration the full package of care delivered to stroke patients in relation to the NICE quality standards

that are captured as part of the Stroke Improvement National Audit Programme (SINAP). This comprises the following quality indicators:

- Number of patients scanned within 1 hour of arrival at hospital,
- Number of patients scanned within 24 hours of arrival at hospital,
- Number of patients who arrived on stroke bed within 4 hours of hospital arrival (when hospital arrival was out of hours),
- Number of patients with a known time of onset for stroke symptoms,
- Number of patients for whom their prognosis/diagnosis was discussed with relative/carer within 72 hours where applicable,
- Number of potentially eligible patients thrombolysed,
- Bundle 1: Seen by nurse and one therapist within 24 hours and all relevant therapists within 72 hour (proxy for NICE Quality Standard No.5),
- Bundle 2: Nutrition screening and formal swallow assessment within 72 hours where appropriate
- Bundle 3: Patient's first ward of admission was stroke unit and they arrived there within four hours of hospital arrival,
- Bundle 4: Patient given antiplatelets within 72 hours where appropriate and had adequate fluid and nutrition in all 24 hour periods.

The Trust has achieved all of the in year milestones agreed with the commissioners for these indicators between April and December, with the sole exception of Bundle 4 where performance was 67% compared to a milestone target of 75%, although in quarter 3 performance increased to 98% against a milestone target of 80%.

Annex One: Statements from our key stakeholders

Statement from Coordinating Commissioners: NHS Sunderland Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group and NHS England

NHS Sunderland Clinical Commissioning Group aims to commission safe and effective services that provide a positive experience for patients and carers. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. This responsibility is taken very seriously and considered to be an essential component of the commissioning function.

Throughout 2012/13 monthly quality review meetings, with CCG representation from NHS Sunderland CCG and NHS Durham Dales, Easington and Sedgefield CCG (DDES) have taken place with City Hospitals Sunderland NHS Foundation Trust. These are well established mechanisms to monitor the quality of the services provided and to encourage continuous quality improvement. The purpose of these meetings is to:

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

NHS Sunderland CCG recognise the good work undertaken in 12/13 and look forward to working with you in 13/14.

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

- continued development of real-time feedback from patients;
- timeliness of X-ray reporting to GPs,
- outpatient appointments cancelled/changed by the hospital,
- timeliness and reporting of pressure ulcers,
- reporting and progress made relating to the National Safety Thermometer,
- improvement in ambulance handover times, and
- timeliness and quality of discharge summaries.

The Trust has experienced significant pressures within the Emergency Department but managed to achieve the national targets by the end of the year. The trust has implemented improvement initiatives within the emergency department and we look forward to working collaboratively with you on these areas which are aligned to the CCG's commissioning plans.

The Trust continues to experience significant challenges in relation to infection control targets for *Clostridium Difficile* and this will continue into 2013/14 with an even more challenging target to deliver a maximum of 36 cases.

A health economy wide improvement plan has been initiated to improve *Clostridium Difficile* rates and Sunderland CCG will have oversight of progress against this collaborative plan.

Reflecting on the challenges experienced in 12/13 regarding the reporting of pressure ulcers, in order to support continued improvement in reporting of pressure ulcers, we intend to build on work started in 12/13 to help improve outcomes for patients.

Sunderland and DDES CCGs look forward working with the Trust to build on the work in 12/13 to improve the timely closure of SIs to ensure the appropriate lessons can be learnt and shared accordingly.

Sunderland CCG, DDES CCG and NHS England agree with the priorities outlined in the Quality Report for 2013/14 and will work in partnership to achieve the common goals of improving access, experience and patient safety for all patients.

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

Annex Two: Statements from director's responsibilities in respect of the Quality Report

Statement from directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2012 to June 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
  - Feedback from the commissioners dated 17/05/2013
  - Feedback from governors dated 25/03/2013
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated23/05/2013;
  - The 2012 national patient survey 16/05/2013
  - The 2012 national staff survey 28/02/2013
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 28/05/2013
  - CQC quality and risk profiles dated 31/03/2013

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

..............................Date...Chairman

..............................Date..Chief Executive

How you can provide feedback on our Quality Report

Production of the Quality Report

We are very grateful to all those who have contributed to the production of this year's Quality Report 2012/13. The Trust welcomes any comments you have about the current Quality Report but also asks you to help shape next years' Quality Report by sharing your views and contacting Corporate Affairs via;

Carol Harries
Director of Corporate Affairs
City Hospitals Sunderland NHS Foundation Trust
Sunderland Royal Hospital
Trust Headquarters
Sunderland

Availability of the Quality Report

If you require this Quality Report in Braille, large print, audiotape, CD or translation into another language, please request one of these versions by telephoning 0191 5656 256 Ext: 49110

Additional copies can also be downloaded from the Trust website; **www.chsft.nhs.uk.**