City Hospitals Sunderland NHS
NHS Foundation Trust

QUALITY REPORT 2010/11

QUALITY REPORT

Part 1: Chief Executive's Statement

City Hospitals Sunderland NHS Foundation Trust is delighted to present its third Quality Report covering the year 2010/11.

Quality Reports assist the public, patients and others to understand:

- what the organisation has done well,
- where improvements in service quality are still required, and
- what the Trust priorities are for improvements in the coming year 2011 /12.

Last year was undoubtedly one of our most challenging; the economic downturn served to create a very difficult operational context. City Hospitals, like many other organisations in the NHS, had to cope with unprecedented and competing service demands whilst needing to protect and improve quality, all against a background of having to make necessary efficiencies and savings. Although at times it has been very difficult for staff struggling to balance these pressures, we believe that we have risen to the quality challenge.

That focus has meant, for example, continuing reductions in healthcare associated infections to our lowest ever level. We now have very robust systems in place for keeping the environment clean, tidy and safe, for prescribing the correct drugs and ensuring our staff adhere to strict hand washing. It is imperative that we ensure our patients are safe from infection, and I believe that everyone is playing their part in maintaining the highest standards of hygiene.

Our aim to both protect and improve quality is now firmly embedded in our corporate objectives and we are working hard to align our internal systems and practices to make quality, safety and the patient experience an integral part of our business. We will continue to be an organisation which aspires to be better, not simply to meet targets but to make care as effective and safe as possible, and in line with the best.

That commitment is enshrined in our new ward block and critical care facilities, which offer first class, ultra modern accommodation for our patients. I'm sure the inconveniences and delays of the new build suffered at the time have long passed and we can now be proud of this significant development. It sends a clear message that we want to provide only the very best and excellence in care for our local community.

Although the Quality Report highlights our many achievements, and rightly so, it does not avoid those areas where we know we need to improve. Our performance in the recent national inpatient survey is improving; patients are telling us that we are getting it right most of the time, but equally as important, they are letting us know where we get it wrong. There are still some issues that we know we still need to do better, and these are highlighted in the Quality Report as our continuing priorities.

With the Quality Report covering such a wide range of issues it is also important for everyone who reads this to have confidence in the accuracy of the information presented. I can confirm that to the best of my knowledge the information reported within this document is accurate.

In setting out the Quality Report we can't possibly cover everything; staff throughout the Trust continually work to improve care, and there are endless examples of excellent

individual practice. The report however does provide a flavour of the quality experience at the Trust, which I hope inspires confidence in our services, and shows our genuine desire to improve.

"Although the Quality Report highlights our many achievements, it does not avoid those areas where we know we need to improve."

K W BREMNER
Chief Executive **Date: 2 June 2011**

Part 2: Priorities for Quality Improvement and Statements of Assurance from the Board

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

Priorities for Quality Improvement – Review of Performance 2010/11

Priority 1: Patient Safety
To further reduce avoidable hospital acquired infection

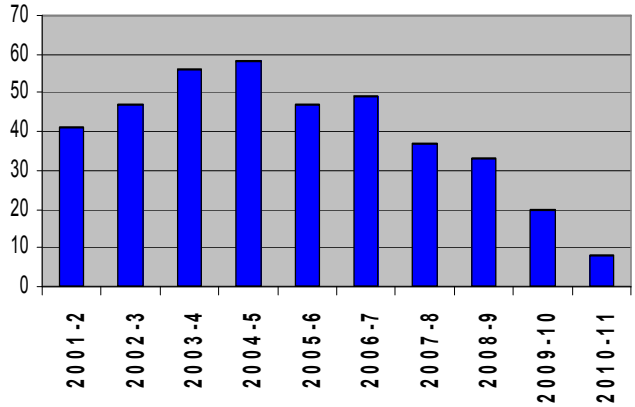
Health Care Associated Infections (HCAI) are infections that are neither present (nor incubating) when a patient enters hospital. About 9% of inpatients have a Health Care Associated Infection, however not all HCAIs are preventable. Although we are delighted with the success in achieving our targets for MRSA and *C. difficile* for 2010/11 we will not be complacent and reducing our MRSA and *C. difficile* rates even further will continue to be a top priority for the organisation. The targets for 2011/12 are very challenging with 6 cases of post-48 hours MRSA and 44 cases of post-72 hours *C. difficile* infection.

How did we do?

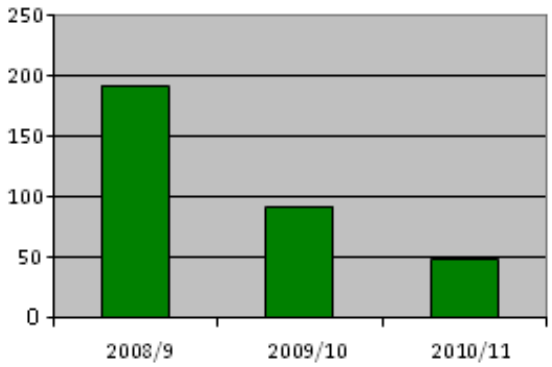
	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Actual	% change	Achieved/ Not Achieved
MRSA bacteraemias	37	33	20	8*	60%	☑
	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Actual		
Clostridium difficile	-	192	93	49	47%	☑

*the 8 cases represent all MRSA cases (both hospital and community acquired) for comparison purposes, of the 8 cases 3 were post-48 hours

MRSA bacteraemia 2001/02-2010/11



Hospital acquired C.*difficile* infection



Achievements

- Our self assessment against the Health and Social Care Act 2008 has identified no areas of non-compliance;
- Continuing success has been demonstrated for our Infection Prevention and Control Ward (F62, a 19 bedded ward with strict infection control measures in place) in managing patients with *C.difficile* infection and viral gastroenteritis. Additional effort to manage patients with MRSA on the ward as CDI cases dwindle is showing early signs of reduced MRSA transmission. Our *C.difficile* infection rates are consistently below the national average rate;
- Screening of all patients for MRSA continues;
- The web-based infection control dashboard is being launched this year and will allow more comprehensive and accessible information about Infection Prevention and Control performance throughout the Trust;
- We have appointed a Senior Infection Prevention and Control Nurse as Head of the Infection Prevention and Control Department;
- Levels of MRSA bacteraemia have now dropped to an all time low, with post 48 hour cases totalling only 3 in the last 12 months;
- Infection Prevention and Control e-learning capability has significantly increased.

Key areas of Improvement

- Continue to ensure the smooth running of the Infection Prevention and Control ward (F62), despite the bed pressures in the Trust;
- Additional enhanced cleaning of clinical areas where cases of CDI have arisen will be undertaken as well as a programme of environmental surveillance for *C.difficile* spores to help identify any hot spots;
- Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemias will now be analysed in detail to try and provide lessons learned for the organisation;
- Mandatory reporting of MSSA bacteraemias and *E. coli* bacteraemias is occurring this year;
- Introduce a new real-time bed management system to better manage beds and track patients who are known to be an infection risk;
- Continue to develop and empower those staff undertaking Clinical and Hand Hygiene Champion roles in wards and clinical areas;
- Greater scrutiny of patients who die within 30 days with a diagnosis of *Clostridium difficile* infection;
- Extend surveillance activity to target multiple specialties within the Surgical Directorate.

Priority 2: Patient Experience
To improve patient experience and overall satisfaction

As a Trust we are committed to improving the quality of patient experience and it is therefore important that we listen to what patients and their families say about their treatment and care so that we can focus on where we need to improve. The Trust's aim was to improve its performance across a range of patient experience measures, including dignity and respect, pain management, choice of food and assisting patients to eat, cleanliness of rooms or wards and the overall rating of care.

How did we do?

Metric	Description	2009 Actual	Source	2010 Actual	Source	Improvement
Dignity & respect	"Did you feel you were treated with dignity and respect while you were in hospital?"	88	National IP Survey	90	National IP Survey	☑
Choice of food and assisting patients to eat	"Were you offered a choice of food?" "Did you get enough help from staff to eat your meals?"	75 68	National IP Survey	83 73	National IP Survey	☑ ☑
Pain management	"Do you think the hospital staff did everything they could to help control your pain?"	80	National IP Survey	79	National IP Survey	☒
Cleanliness of rooms or wards	"How clean was the hospital room or ward that you were in?" "How clean were the toilets and bathrooms that you used?"	85 83	National IP Survey	88 85	National IP Survey	☑ ☑
Overall rating of care	"Overall how would you rate the care you received" (% of patients who said 'Good' and above)	77	National IP Survey	80	National IP Survey	☑

Key areas of Improvement

Food & Nutrition (Nutrition Steering Group)

- Public display of menus on all wards with the ward hostess checking that a menu is at each bedside prior to meal service. The menu is now featured as an integral part of the admission process;
- Ward staff now ensure that patients are given a menu to enable them to choose their meal. If the patients' choice of meal is not available, staff are asked to provide an explanation;
- Ward staff reminded to reinforce protected meal times; and
- Re-launch of information on each ward's catering related performance.

Cleanliness of Wards

- Regular programme of spot checks undertaken by Matrons to identify persistent, problematic areas and clear lines of communication for taking action;
- Ward areas undertaking Infection Control Environmental Audits.

Dignity & Respect

- Information about privacy and dignity to be included in new Bedside Information Folders;
- Staff made aware of the importance of maintaining privacy and dignity for patients when in hospital, particularly when involved in visiting other departments or moving through public areas.

Pain Management

The work of the City Hospitals' Pain Management Group has had mixed success in 2010/11. One of our improvement areas was to increase the percentage of patients who have a pain score documented on admission. The annual Hospital Wide Level of Care and Early Warning Score Point Prevalence Study 2010 revealed that 88% (n=574) of patients had a pain score documented on their observation chart. In 2009 only 48% (n=324) of patients had a pain score documented. Whilst there is room for improvement, this demonstrates substantial progress in recording what is now considered the "5th vital sign" (Chronic Pain Policy Coalition 2008).

However we have had less success in introducing measures to reduce the number of omitted and delayed analgesia. Given that the issue of pain management is still a concern to patients, the group will reflect and refocus on this area for 2011/12. We are confident that the national Essence of Care benchmarking tool on pain (due to be released in October 11) which highlights areas of best practice will help to regain our focus in tackling this issue.

Deteriorating Patient

Metric	2009/10 Baseline	2010/11	Monitoring Group	Source
Reducing the number of incidents and complaints relating to handover of care issues (where a patient is transferred from one consultant team to another).	Not* available	37	Deteriorating Patient Group	Incident reporting system

Progress

- Implementation of a revised clinical handover process for all patients being transferred from the Acute Medical Unit (AMU) to base wards,
- Clinical handover is included in the Leading Improvements in Patient Safety (LIPS) programme (under the broad objective of improving the management of the deteriorating patient).

* Not previously identified as a specific cause group within either the complaints or incident database – this has now been addressed in order that accurate figures will be available for future reports.

Metric	2009/10 Baseline	2010/11	Monitoring Group	Source
Improving the recording and recognition of, and response to, clinical observations (vital signs), particularly in patients whose condition is deteriorating. This is monitored by the number of incidents reported and by the number of complaints received.	48 11	48 1	Deteriorating Patient Group Deteriorating Patient Group	Incident reporting system Complaints Database
Progress • Rollout of critical skills training across the Trust; • Establishment of quarterly lessons learned seminars; • Outcomes of inquests and Root Cause Analysis (RCA) investigations provided to Clinical Governance Leads who are then tasked with ensuring that the lessons learned are shared and acted upon across their area of responsibility, • Further review of the Trust observation (vital signs) chart.				

Whilst the figures indicate that the number of incidents relating to this specific area have remained constant, there has been an increase in the percentage of incidents reported as 'near misses', 18.75% in 2009/10 to 22.9% during 2010/11. This indicates increased awareness and closer monitoring of the Early Warning Score (EWS) system used to identify deterioration in a patient's condition. This is supported by the significant decrease in the number of complaints raised with regard to this issue.

Specific cause group categories have now been established on the incident and complaints database to facilitate good data capture, which enables the Deteriorating Patient Group to monitor trends and themes.

A Trust study revealed that 95% (n=615) of patients' EWSs were recorded accurately. Previous studies showed 91% (2009) and 81% (2008) were recorded accurately (Source – Hospital Wide Level of Care and Early Warning Score Point Prevalence Study 2010).

Metric	2009/10 Baseline	2010/11	Monitoring Group	Source
Improving the methods of communicating treatment and clinical monitoring plans for patients.	Not available	8	Deteriorating Patient Group	Complaints Database

This is not a specific cause group within the incident database and is not a recognised sub section of incident reports as identified by the National Patient Safety Agency (NPSA) with such issues being logged under the generic cause group of communication. The complaints database cause groups have now been expanded to allow capture of this data to see if trends and themes emerge.

Communication and Record Keeping

Metric
Improving communication and supportive documentation for patients in relation to outpatient appointments.
Progress • Reviewing and improving the content of appointment letters; • Reducing patients cancellations and Did Not Attends (DNAs).

Metric
Improving the standards of clinical record keeping
Progress • Awareness brief on the clinical record keeping policy for staff – "Top 10 Tips for Good Record Keeping", • Undertaking record keeping audits as part of local clinical governance systems.

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

This challenging aim was to reduce the incidence of patient falls by 10% and reduce the number of incidents resulting in moderate, major and catastrophic injury.

How did we do?

Metric	Description	2008/09 Actual	2009/10 Actual	2010/11	Source
Hospital falls	Number of falls (including all slips and trips)	-	1825	1636	Incident system
	Number of falls (with associated injury*)	26	42	57	Incident system

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

Key areas of Improvement

- There has been a 10.35% reduction in the number of falls reported (1825 to 1636);
- The patient Falls Risk Assessment tool is now accessible to clinical staff via the HISS system;
- An e-learning programme has been developed to assist staff training in the management of patients at risk of falling;
- Weekly monitoring of all patient falls has been established and this information is fed back to wards;
- The introduction of a Falls Co-Coordinator who works closely with ward staff to minimise risks for patients identified following assessment as having a high risk of falling.

Priorities for Quality Improvement in 2011/12

For 2011/12 we have agreed the following quality priorities for improving our services. We considered these priorities following extensive review and reflection on our current performance in these areas, through discussion with key clinical and management staff, as well as feedback from patients and the public. We have considered a range of external and internal data sources and monitoring mechanisms, which include the following:

- Care Quality Commission essential standards of quality and safety;
- Clinical Negligence Scheme for Trusts accreditation standards and reports;
- National and local surveys and patient feedback; and
- Analysis of complaints and incidents.

For each priority for improvement we have stated why we have decided to focus on that area and how progress will be monitored.

Category		Priority	
Clinical Effectiveness	**1.**	**Reduction in avoidable hospital acquired infection**	
		1a	- MRSA bacteraemia
		1b	- *Clostridium difficile* infections
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

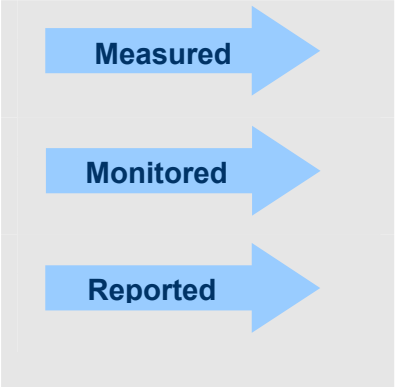
Priority 1: To Further Reduce the Rates of Avoidable Hospital Acquired Infection

Over the past few years we have made significant achievements in reducing hospital acquired infections through the constant vigilance of staff who have made infection control their personal and team responsibility. The importance of hand hygiene is now fully understood by all staff and is visible through our "bare below the elbows" patient contacts, the presence of gel dispensers throughout wards and departments, and more widely with the general public through visible promotion of good hand hygiene practices.

Whilst we can all claim to have played a part in this success, our next biggest challenge is avoiding complacency; this is why we will continue to keep hospital acquired infection a top clinical priority. For 2011/12, the Trust has an even more challenging target of:

- not exceeding 6 post-48 hours MRSA bacteraemias and,
- not exceeding 44 post-72 hours cases of C.*difficile* infections.

How progress will be monitored



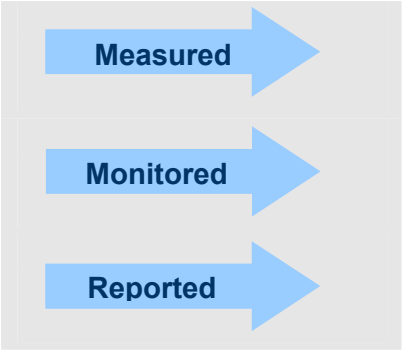
- Number of reported and confirmed cases of MRSA bacteraemia (post-48 hours) and C.*difficile* (post-72 hours)
- Director of Infection Prevention and Control
- Winning Ways Implementation Group

- Corporate and specialty Service Line Reporting (SLR) clinical dashboards
- Clinical Governance Steering Group
- Board of Directors reports

Priority 2: To Improve Patient Experience and Overall Satisfaction in Key Areas

There are certain aspects of the patient experience that we know we need to improve. Despite our efforts last year our feedback from patients shows that we still have more to do. That is why improvements to the patient experience will remain a key priority for the Trust next year. Our corporate objectives reflect this goal and that expectation will also be included in local directorate and clinical team objectives; this ensures that we all have a responsibility to making improvements to the patient experience 'our business'.

In 2011/12 we will specifically focus on the rating and choice of hospital food, the management of patients' pain and various aspects of communication, particularly involving older people. This does not mean that other aspects of care are ignored, but we are determined to show improvement in these specific areas which matter so much to patients.



- National Patient Survey 2011
- Results from real-time patient feedback
- Number of reported incidents and formal complaints
- Monthly real-time feedback reports and cumulative scorecard
- Patient & Public Involvement Steering Group
- Clinical Governance Steering Group
- Board of Governors
- Executive Board / Board of Directors

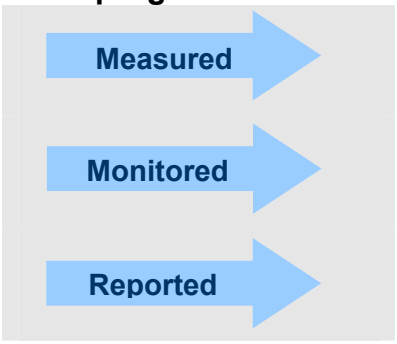
Priority 3: To Improve the Management of the Deteriorating Patient

The health of a patient in hospital may unexpectedly get worse. This can happen at any stage of an illness but is more likely following an emergency admission to hospital, after surgery or after leaving critical care. Deterioration may lead to patients staying in hospital longer, not fully recovering or dying. Checking patients' vital signs (temperature, blood pressure, pulse and respiration rate) regularly can be used to establish a score which will give an early indication of deterioration; this is called the Early Warning Score (EWS). If the EWS shows signs that the patient's condition is becoming worse taking prompt action can help avoid serious problems.

Incidents reported by staff, local audit data and review of mortality cases have sometimes shown that patients vital signs were not always recorded in a timely manner and that, on occasion, the EWS were not acted upon in time to prevent further deterioration in a patient's condition. Given the impact this has on patient outcomes we have identified this as a priority area for improvement.

The Trust has restructured and revitalised its Deteriorating Patient Group to help the Trust focus on this priority. Improving the management of the deteriorating patient is also a key objective within the Leading Improvements in Patient Safety (LIPS) programme, which includes a range of initiatives to improve the recognition and response to those patients whose condition deteriorates.

How progress will be monitored



- Global Trigger Tool review of mortality
- Annual level of care report

- Reported incidents of patient deterioration
- Deteriorating Patient Group

- Clinical Governance Steering Group
- Executive Board / Board of Directors

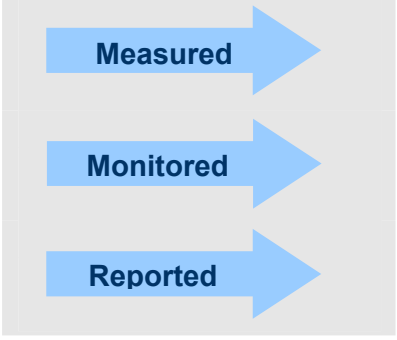
Priority 4: To Reduce the Number of Patient Slips, Trips and Falls and Harmful Falls

Patients of all ages can fall in hospital but the rate is likely to be higher in the elderly, particularly when they are acutely unwell. Of particular concern are falls which contribute to a patient's death or those falls which result in harm, particularly fractures, as these can prolong hospital stay and may decrease the likelihood of return to previous levels of independence. In spite of our focus on falls prevention and management last year, and with a decrease in the total number of falls, we believe we can improve even further and also reduce the number of potentially harmful falls, ie those associated with fractures.

Reducing falls is also a part of our Commissioning for Quality and Innovation (CQUIN) agreement with NHS South of Tyne & Wear Primary Care Trust as well as a key component of our patient safety programme (Leading Improvements in Patient Safety - LIPS).

Our goal will be to reduce the incidence of falls by 10% and prevent the number of incidents that result in major or catastrophic injury.

How progress will be monitored



- Incident reporting system

- Quality Review (Monthly) meetings
- Trust Falls Committee

- Reports to Clinical Governance Steering Group
- Reports to Executive Board / Board of Directors

In addition to these quality priorities, after consultation with clinical teams, various internal quality committees and patient groups we have agreed to the following indicators for quality improvement in 2011/12:

Indicators for Quality Improvement in 2011/12

Patient Safety				
Metric	**Description**	**Source**	**Rationale**	**Monitoring Group**
Hospital mortality	To reduce mortality Risk Adjusted Mortality Index (RAMI) through a series of targeted interventions	Caspe Healthcare Knowledge System (CHKS)	• High Hospital Standardised Mortality Ratio (HSMR) • 'Worse than expected' mortality in Care Quality Commission (CQC) Quality & Risk Profile	Clinical Governance Steering Group
Pressure Ulcers (Sores)	Reduce the number of grade 3 & 4 pressure ulcers	Internal (Safeguard system)	• QIPP safe care work stream • CQUIN goal 2011/12	Tissue Viability Group – Nursing & Quality
Discharge arrangements	Improve the quality of discharge communication between the Trust and Primary Care	Internal	• LINk feedback (2010) • GP survey (2010) • Issues raised by PCT	Clinical Governance Steering Group
'Never Events'	Eliminate any occurrence	Internal systems, ie Safeguard, Pharmacy HISS module etc	• Operating Framework 2011/12 • Never Events list 2011/12	Risk Management / Clinical Governance

Clinical Effectiveness				
Metric	**Description**	**Source**	**Rationale**	**Monitoring Group**
Hospital readmissions	To reduce the number of avoidable readmissions relating to Chronic Obstructive Pulmonary Disease (COPD)	CHKS	• Penalty schedule • Payment by Results (PbR)/ new tariff system • CQUIN goal 2011/12 (under long term conditions)	Performance / Information Services

Clinical Effectiveness				
Metric	**Description**	**Source**	**Rationale**	**Monitoring Group**
Reporting Times for Radiology	Improve internal reporting times for X-rays and ultrasound scans	Internal (Data repository)	• Radiology Clinical Governance Review	Performance – Corporate dashboard
End of Life	Increase the number of patients on the Liverpool Care Pathway as a proportion of those expected to die	Internal	• CQUIN 2011/12 goal	End of Life Steering Group

Patient Experience				
Metric	**Description**	**Source**	**Rationale**	**Monitoring Group**
Eliminate mixed sex accommoda-tion	Minimising use of same bathroom or shower area for patients of the opposite sex	Internal	• DH commitment – linked to penalty schedule • Include focus on Care of the Elderly (Governors / LINks issue)	Performance / Nursing &Quality / Facilities
Communication indicators	Informed and involved in decisions about care and treatment	National inpatient survey Real Time Feedback	• DH National inpatient survey • Include focus on Care of the Elderly (Governors / LINks issue)	Patient and Public Involvement Committee
	Staff listen to concerns and answer questions			
	Staff polite and professional			
	Staff inform about medication side effects			
	Given all the information needed for discharge home			

Patient Experience				
Metric	**Description**	**Source**	**Rationale**	**Monitoring Group**
Overall satisfaction	"Overall how would you rate the care you received" (% of patients who said 'Good' and above)	NHS Patient Survey	• DH National inpatient survey • Include focus on Care of the Elderly (Governors / LINks issue)	Real Time Feedback / Clinical Governance

Statements of Assurance from the Board

Information on the Review of Services

During 2010/11 City Hospitals Sunderland provided and/or sub-contracted 40 NHS services.

City Hospitals Sunderland has reviewed all the data available to them on the quality of care in 17 (42%) of these NHS services during 2010/11. This ensured the Trust completed the planned programme of Clinical Governance Reviews of all clinical directorates and specialties by November 2010 as part of a two-yearly cycle (the other 58% were completed in 2009/10).

This involved a comprehensive review of their clinical governance activities, for example:

- how they manage and mitigate risks;
- have they participated and learnt from clinical audit;
- do they act on the findings from complaints and surveys; and
- is national 'best practice' being followed.

The process has been invaluable in identifying quality issues that need to be addressed as well as showcasing good areas of practice. Another 'round' of Clinical Governance Reviews is planned for the next 2 years.

The income generated by the NHS services reviewed in 2010/11 represents approximately 49% per cent of the total income generated from the provision of NHS services by City Hospitals Sunderland for 2010/11.

Clinical Negligence Scheme for Trusts (CNST) General Level 1 Accreditation (September 2010)

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

In September 2010, the Trust was assessed against the Level 2 risk management standards. Unfortunately we were unsuccessful in achieving the Level 2 standard but we did retain our Level 1 status.

Whilst everyone was disappointed with the outcome of the assessment, we have taken the opportunity to revise and update our governance arrangements (a key reason for not

achieving Level 2) and we now believe that we have a much more rigorous process in place which will contribute to embedding risk management and patient safety into the organisation's culture and provide external assurance to the Trust Board, other inspecting bodies and stakeholders (including patients) that the Trust is doing the right things to minimise risk and harm to patients.

Our aim is to be ready for Level 2 assessment in 2012; the first opportunity we have for undertaking that level of assessment.

Accreditation Schemes

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

- **Clinical Pathology Accreditation (UK) Ltd (CPA)** – This is nationally recognised as providing a set of minimum quality standards for pathology laboratories. All disciplines (Histopathology, Haematology, and Biochemistry), with the exception of Microbiology, retained accreditation. Microbiology achieved provisional accreditation on the condition of further evidence being made available within a set time frame.

- **Pharmacy Accreditation** – The manufacturing unit has a biennial inspection undertaken by the Medicines and Healthcare Products Regulatory Agency (last inspection was in October 2009) and also an external audit from the regional Quality Control Service (2010). No licences were withheld and the audits/assessments were all passed.

- **Human Fertilisation and Embryology Authority (HFEA) licence** - In April 2010, the Sunderland Fertility Centre moved from its location in the old Kayll Road block to a new, purpose built unit in Chester Lodge. Before the move had been completed, the new centre was inspected by a team from the Human Fertilisation and Embryology Authority (HFEA), which is the governing body of assisted conception units in the UK. The inspectors from the HFEA were impressed by the design and facilities of the Centre, and the Centre's licence was transferred to the new location. In December 2010, inspectors from the HFEA visited the Centre again for an interim inspection, aimed at ensuring compliance with the relevant laws and directions regulating assisted conception practices. The inspection report was discussed by the HFEA licensing committee and Sunderland Fertility Centre was granted continuation of its licence without attached conditions.

External Assessments/Visits

- **General Surgery:** The Quality Assurance lead for the National Abdominal Aortic Aneurysm (AAA) screening programme has been tasked with visiting every unit planning to undertake repair of AAAs. Units are measured against 11 standards, each being graded 1-4 (1=standard not met, 2=partially met, 3=almost met, 4=fully met or exceeded). City Hospitals achieved 4 out of 4 for ALL 11 standards. The assessor complimented the multidisciplinary team approach and aneurysm work up measures. The assessor went so far as to say that it was the most impressive set up she had seen so far.

- **Trauma & Orthopaedics (T&O):** T&O underwent an inspection from the Human Tissue Authority in March 2011. The inspection focused on two main areas: the process, storage and patient arrangements for the use of human tissue in an ACI procedure (Autologus Chondrocyte Implantation) and the use of femoral heads. T&O successfully passed the inspection which confirmed that they had good policies and procedures in place for the storage and use of human tissue.

Cancer Peer Review

National Cancer Peer Review (NCPR) is a national quality assurance programme for NHS cancer services. The programme involves both self-assessments by cancer service teams and external reviews of teams conducted by professional peers, against nationally agreed "quality measures". During 2010/11 the following tumour sites within Cancer Services were assessed;

Tumour site	Compliance	Type of assessment
Breast	80.0%	Formal Peer Review visit
Head & Neck	95.5%	Self assessment (SA) with external verification (EV)
Thyroid	94.3%*	Self assessment (SA) with external verification (EV)
Colorectal	90.2%	Self assessment (SA) with external verification (EV)
Urology	95.9%	Self assessment (SA) with internal validation (IV)
Penile	76.2%	Self assessment (SA) with internal validation (IV)
Lung	87.1%	Self assessment (SA) with internal validation (IV)
Upper GI	81.8%	Self assessment (SA) with internal validation (IV)
Gynaecology	83.3%	Self assessment (SA) with internal validation (IV)

* Unconfirmed

Formal Peer Review (Breast Cancer)

Breast Cancer was the only area in 2010/11 to have a formal peer review visit. The areas of good practice highlighted by the external assessors included:

- Implementation of the Holistic Assessment Framework which is nationally recognised,
- Excellent team spirit despite challenging circumstances relating to staffing. Team remain positive and patient focused,
- Commended for the survivorship initiative which reflects the Cancer Reform Strategy recommendation,
- No immediate risks or serious concerns identified

Areas for improvement included:

- Both breast surgeons did not perform the minimum number of operative procedures in the reporting period,
- Further work to re-establish the 'one stop' clinic,
- Sentinel node biopsy should be expedited,
- Access to level 4 psychology support needs to be available.

Action plans have been issued to each multidisciplinary team and meetings commenced to advise on compliancy levels and requirements relating to the documentation.

NHS Maternity Services Survey

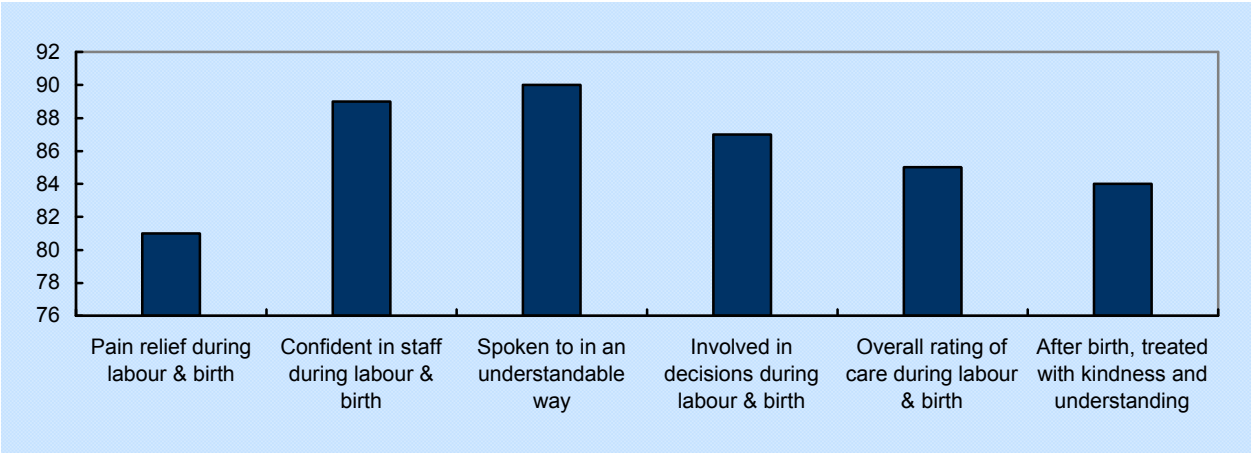
In 2010 City Hospitals took part in the national survey of maternity services which forms part of the national programme of NHS patient surveys. Women were asked to give their views on all aspects of their maternity care from the first time they saw a clinician, to care provided at home in the weeks following the birth of their baby.

City Hospitals performed very well compared with its peers and the findings show that mothers (and their partners) rate highly the quality of care provided by the Trust. The positive experiences of women extend across the three stages of care; antenatal care, labour and birth and postnatal care. Overall, City Hospitals was rated amongst the best 20% of acute Trusts in over half of the questions reported ("Green scores"). In fact the Trust achieved the highest number of green scores in the North East region.

Key findings from the Maternity Services Survey 2010 – comparison ratings (NHS choices)

Survey themes	How our score compares with other trusts
For questions about: **- care during pregnancy (antenatal care)**	WORSE / ABOUT THE SAME / BETTER
For questions about: **- labour and birth**	WORSE / ABOUT THE SAME / BETTER
For questions about: **- staff during labour and birth**	WORSE / ABOUT THE SAME / BETTER
For questions about: **- care in hospital after the birth (postnatal care)**	WORSE / ABOUT THE SAME / BETTER
For questions about: **- feeding the baby during the first few days**	WORSE / ABOUT THE SAME / BETTER

Key findings from the Maternity Services Survey 2010 – percentage (%) of women reporting



There were only two "red scores" reported in the survey, and these related to mothers being offered a home birth and the time mothers waited for stitches following an episiotomy or tear. An action plan has been developed to address these weaker areas which will be monitored by the Maternity Directorate in collaboration with the Maternity Services Liaison Group.

How did our patients think we did?

The hand written comments of the mothers have also been reviewed and they have substantiated the positive findings of the quantitative data.

"I would just like to say I had the best midwives during the pregnancy and while I was in labour. They made the whole experience magical and very comfortable and unforgettable; they deserve a big thank you. They were amazing and helped me and my boyfriend more than I could say"

""All my maternity care was excellent. The help and friendliness of staff at the hospital was exceptional"

"The support I received in Sunderland Royal Hospital was 2nd to none. The midwives, consultants and all staff were outstanding. Although i had a previous serious medical condition I at no time felt worried that I wasn't being cared for by competent staff."

CHKS – Clinical Practice (Service) Benchmarking

Caspe Healthcare Knowledge System (CHKS) are an independent provider of healthcare information and intelligence which hospitals can use to review and improve their services. The system allows Trusts to benchmark or compare performance against other hospitals and to identify any areas of concern or of good practice. The system allows reviews of performance across all specialties and most services.

Within City Hospitals, the tools within the CHKS system are available to clinical and managerial staff and certain areas of quality, safety and effectiveness are routinely monitored including:

- Mortality
- Complication rates
- Length of stay
- Day case rates
- Readmission rates
- Outpatients ie Did Not Attend rates

The Boards receive detailed reports on any alerts raised at specialty level and a summary of areas where there are variations in performance. Actions are taken to resolve any performance issues.

GP Survey

During 2010, all GP Practices in South of Tyne and Wear and Durham were invited to take part in an online survey to find out from GPs and their practice staff what they thought about the Trust in relation to key areas such as quality and performance, staff attitudes, behaviours and communication. The findings of the survey would show the important issues the Trust needed to improve upon and also inform development of a new marketing strategy.

The survey rated specialties such as Ophthalmology and Head and Neck highly when compared to other Trusts and showed that GPs valued our range of surgical specialisms and access to computer results. However there are things we need to improve and challenges to address in order to improve how we work together.

Improving our communication and engagement

Firstly we needed to improve the levels of communication and engagement with GPs and their practices. In response the Trust publishes an online bulletin ("Keepin**G P**osted" – *see screen shot below*) every 6 weeks to keep GPs updated with developments and performance at the Trust. In addition we have established a PBC Clinical Forum, which will enable the Trust to build effective working relationships and facilitate discussions on service issues and developments. The Trust also re-launched its new public facing internet site at the end of the year, and includes a section specifically for GPs and their staff.

Challenges we need to address

The GP survey told us the things we need to address, and includes:

- Discharge communications,
- Clinic letters and outpatient booking process,
- Radiology reporting,
- Urology appointments,
- General nursing and patient care.

For some of these issues GPs have already helped with suggestions for improvements, eg timeliness and quality of discharge communications. For other areas, further work is required in order to clarify expectations and agree areas for improvement. That next stage of work has also involved the LEAN Improvement Team using tools and techniques to improve some of the important clinical processes between the hospital and primary care as highlighted overleaf.

Example - timeliness and reliability of radiology reporting

The timeliness and reliability of radiology reporting was highlighted as an issue in the online survey. The aim was to reduce reporting times for plain film x-rays to 2 working days and implement an electronic system for ordering and delivering reports.

Previously the reporting of plain film x-rays took on average 12 days from the image being taken to the signed report being available to the referring GP. Further delays were added in the production and sending of the paper report. Through the adoption of LEAN methodology, the radiology team have internally restructured the way in which the service is delivered. They held a 2 day Rapid Process Improvement Workshop (RPIW) to design an improved process in order to improve quality, tracking and lead times for reporting. Improvements in radiology reporting times have been achieved, currently at an average of 3 days and this has been shared with GPs and their teams.

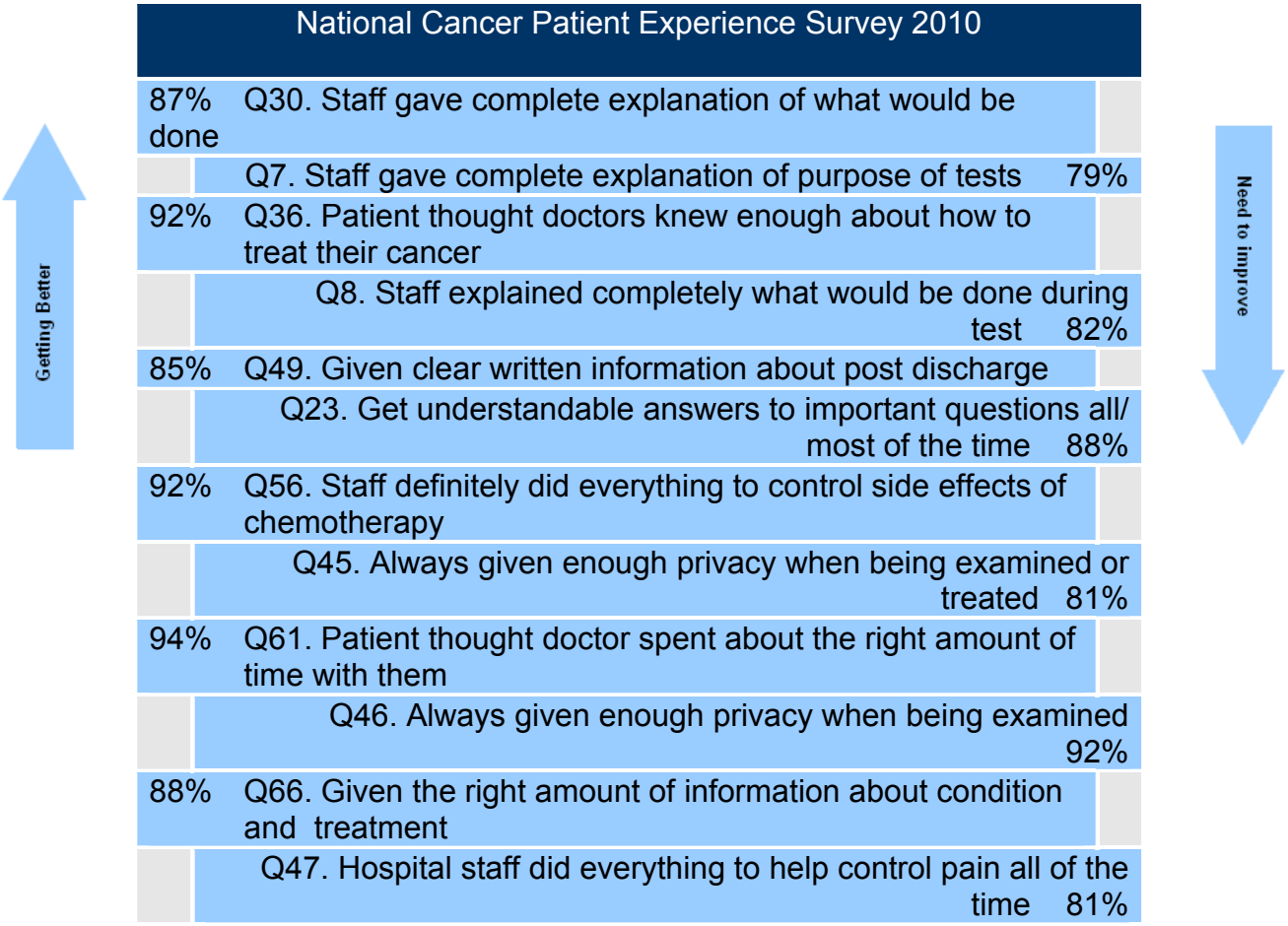
National Cancer Patient Experience Survey

As part of the implementation of the National Cancer Reform Strategy, patients from across the country were asked to give their views on the cancer services they received from the time they were referred to hospital, had tests to find out what was wrong, and underwent treatment until the time their care was transferred back to their GP. The national cancer patient survey is designed to monitor progress on cancer care and to provide information for hospitals that can be used to drive local quality improvements. The national response rate was 67%, a rate of return matched by City Hospitals, with 525 completed questionnaires, and detailed findings are summarised for each tumour group, ie breast, lung, prostate.

The table below shows a 'high level' overview of the spread of results for each major survey theme.

Survey theme	Benchmarking ratings		
Seeing your GP	1	3	
Diagnostic tests		4	
Finding out what was wrong with you		4	
Deciding the best treatment for you		4	
Clinical Nurse Specialist	2	1	2
Support for people with cancer		3	
Operations		4	
Hospital doctors		4	
Ward nurses		4	
Hospital care and treatment	1	5	
Information prior to leaving hospital and home support		2	2
Hospital care as a day patient / outpatient		5	2
Care from your general practice		2	
Your overall NHS care		2	1

The colour bars represent the range of scores across all Trusts that took part and is divided into, a red section (lowest scoring 20% of Trusts), a green section (highest scoring 20%) and an amber section (remaining 60%). The value in each 'bar' shows the number of questions in that category rather than a 'score', eg there were 4 questions related to 'Seeing your GP', 3 scored an amber rating and 1 a red rating. Out of 58 reported questions, three quarters occupied an amber section (74%), 14% red and 12% green. The table below highlights the top 6 questions where we are getting better and those areas where we need to improve:



How did our patients think we did?

The cancer survey questionnaire included three sections where patients could make comments in their own words about the cancer care they had received. The comments were under the following headings:

Was there anything particularly good about your cancer care?

"I was treated with all care and respect at all of the hospitals I attended at for my cancer care the doctors and staff where all very good and treated me and my family very well. I have no complaints whatsoever. Thank you and very much for your care."
(Patient with breast cancer)

"I always felt in good / safe hands with the consultants. Whenever I spoke to the specialists they put me at ease and always spoke to me positively but realistically. "(Patient with gynaecological cancer)

"First class. From the first diagnosis of my lung cancer through my surgery and onward to the end of my chemotherapy, I received what could only be described as FIRST CLASS TREATMENT." (Patient with lung cancer)

Was there anything that could have been improved?

"A clearer more concise explanation of the side effects of drugs administered especially those administered during and after operation eg side effects of morphine."
(Patient with prostate cancer)
"Following my first appointment a biopsy was taken - this was unexpected it may be something that could be added to the letter that this may be a possibility so you are

prepared and may wish to take someone with you." (Patient with prostate cancer)

"There should be a better choice of menu and improved quality of food." (Patient with breast cancer)

Any other comments

"Only thing lacking at Sunderland Royal Hospital is parking, have to leave home most times 2 hours early to get a space. Otherwise every department I have been to are spot on." (Patient with breast cancer)

"Waiting area for patients and accompanying relation/friend is too small for the numbers involved." (Patient with haematological cancer)

Internal Audit Review of Services

The role of internal audit is to provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively. As part of their work programme 2010/11 Internal Audit reviewed a number of areas within the Trust:

- patient experience
- risk management
- clinical audit.

Patient Experience assessed the adequacy of the Trust's strategies for collating and monitoring patient experience information and using it to drive improvements in the quality of patient care. This was primarily done through a self-assessment checklist, developed by internal auditors and completed by key Trust staff. The checklist was subsequently reviewed and approved by the Patient and Public Involvement (PPI) Steering Group.

In terms of providing an assurance rating for the review, the following statement was recorded;

"On the basis of the work carried out, significant assurance can be given that there is a generally sound process for collecting and learning from information about patient experience. However, there are some areas, principally triangulating data and ensuring that action plans are developed and implemented, in which it could be strengthened"

Risk management reported that the Trust had effective arrangements in place:

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

The clinical audit review has been completed and we are waiting for the agreed and approved assurance rating from Internal Audit.

Health & Well-Being Scrutiny Committee – Malnutrition and Dehydration in Hospitals

In 2010 an external review was undertaken of malnutrition and dehydration by the Sunderland Health & Well-Being Scrutiny Committee. The topic was chosen following concerns raised nationally about the support and feeding of patients in hospital, particularly older people. The review was wide ranging and covered the management of the whole meals process as well as the identification and care of those patients vulnerable to malnutrition and dehydration.

The review found evidence of continuous service developments year on year and a commitment among all those involved in the meals service to improve the experience for patients. Committee members were encouraged when observing examples of good practice; however this did not happen on all wards and there was a small number of recurring messages from patients where further improvements can be made. In their feedback report the Committee identified a number of areas for improvement that we will be taking forward in 2011/12. These include:

- clearly defining responsibilities for making sure patients have their nutritional needs supported and their experience of mealtimes improved;
- ensuring rigorous monitoring and reporting to the Board on critical aspects of nutritional care, including adequate risk assessment of vulnerable patients (using the MUST tool) and appropriate management of the 'at risk' patient;
- using all available communication tools to raise the profile of good nutritional care, for example, newsletters, bulletin boards, and internet, similar to the 'Wash Your Hands' campaign;
- maximising patient choice of meals and reviewing how the menus are used, including alternative menu choices;
- further enhancing assistance to patients by potentially providing a red tray system to ensure a link between a patient needing assistance and an uneaten meal left on the plate.

The Trust will formally respond to this review and its recommendations in June 2011 when the review is presented to the Local Authority Cabinet.

Information on Participation in Clinical Audits and National Confidential Enquiries

During 2010/11, 44 national clinical audits and 5 national confidential enquiries covered NHS services that City Hospitals Sunderland provides.

During that period the Trust participated in 68% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

Details are provided overleaf which identify 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 Audit and Patient Outcome Programme 2010/11			
National Clinical Audits	**Eligible for participation**	**Participation**	**Compliance**
Peri and neonatal			
Perinatal mortality (CEMACH)	☑	☑	Continuous data collection.
Neonatal intensive and special care (NNAP)	☑	☑	Continuous data collection.
Elective procedures			
National joint registry	☑	☑	Continuous data collection.
National PROMs programme (elective surgery)	☑	☑	Continuous data collection.
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
Liver transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
Coronary angioplasty (Adult cardiac intervention audit)	☑	☑	Continuous data collection.
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	☑	☑	Continuous data collection.
Carotid interventions audit	☑	☑	Continuous data collection.
Adult cardiac surgery audit	N/A	N/A	N/A
Children			
Paediatric pneumonia (BTS)*	☑	☒	No data submitted.
Paediatric asthma (BTS)	☑	☑	100% compliance 12 cases submitted.
Paediatric fever (College of Emergency Medicine)*	☑	☒	No data submitted.
National childhood epilepsy audit (RCPH)	☑	N/A	Data collection begins May 2011.
Paediatric intensive care (PICANeT)	N/A	N/A	N/A
Paediatric cardiac surgery (NICOR Congenital heart disease audit)	N/A	N/A	N/A
National paediatric diabetes audit (RCPH)	☑	☑	Continuous data collection.
Acute care			
National cardiac arrest audit	☑	☑	Continuous data collection.
Adult critical care (Case mix programme)	☑	☑	Continuous data collection.
Vital signs in majors (College of Emergency Medicine)	☑	☑	100% compliance. 40 cases submitted.
Potential donor audit (NHS Blood Transfusion)	☑	☑	Continuous data collection.

National Clinical Audits	Eligible for participation	Participation	Compliance
Emergency use of oxygen (BTS) **	☑	☒	No data submitted.
Adult community acquired pneumonia (BTS) **	☑	☒	No data submitted.
Adult non invasive ventilation (NIV) (BTS) **	☑	☒	No data submitted.
Pleural procedures (BTS) **	☑	☒	No data submitted.
Cancer			
National lung cancer audit (LUCADA)	☑	☑	Continuous data collection.
Bowel cancer (NBOCAP)	☑	☑	Continuous data collection.
Head and neck cancer (DAHNO)	☑	☑	Continuous data collection.
Long-Term Conditions			
National diabetes audit (Adults)***	☑	☒	No data submitted.
National audit of heavy menstrual bleeding (RCOG)	☑	☑	Continuous data collection.
National pain audit	☑	☑	Continuous data collection from March 2011for 3 months.
UK inflammatory bowel disease	☑	☑	100% compliance. Organisational data and 40 cases submitted.
National Parkinson's audit ****	☑	☒	No data submitted.
Chronic obstructive pulmonary disease (BTS)**	☑	☒	No data submitted.
Bronchiectasis (BTS) **	☑	☒	No data submitted.
Adult asthma (BTS) **	☑	☒	No data submitted.
Cardiovascular			
National audit of the management of familial hypercholesterolemia	☑	☑	100% compliance. Organisational data and 41 cases submitted.
Acute myocardial infarction (MINAP)	☑	☑	Continuous data collection.
Heart failure	☑	☑	Continuous data collection.
Pulmonary hypertension audit	N/A	N/A	Designated centres only.
Acute stroke (SINAP)	☑	☑	Continuous data collection.
National sentinel audit of stroke	☑	☑	100% compliance. Organisational data and 60 cases submitted.
Renal			
Renal replacement therapy (Renal Register)	☑	☑	Continuous data collection.
Renal transplantation (UK Transplant Register)	N/A	N/A	N/A
Renal colic (College of Emergency Medicine)	☑	N/A	Audit does not commence until 2012.
National Kidney Care (patient transport)	☑	☑	100% compliance with study requirements.

National Clinical Audits	Eligible for participation	Participation	Compliance
Trauma			
Hip fracture (National Hip Fracture Database)	☑	☑	Continuous data collection.
Severe trauma (Trauma Audit and Research Network)	☑	☑	Continuous data collection.
National falls and bone health audit	☑	☑	100% compliance. Organisational data and 60 cases submitted.
Psychological conditions			
National audit of psychological therapies	N/A	N/A	N/A
Prescribing in mental health services	N/A	N/A	N/A
National audit of schizophrenia	N/A	N/A	N/A
Blood transfusion			
National comparative audit of blood transfusion (O neg blood use)*****	☑	☒	No data submitted.
National comparative audit of blood transfusion (Platelet use)	☑	☑	100% compliance. 40 cases submitted.

* No data submitted due to clinical pressures and lack of resource. If possible specialty intends to take part in the next round
** No data submitted due to intensity of workload within chest medicine and lack of resource
*** Specialty feels this audit is essentially for Primary Care. Metabolic Medicine currently takes part in the National Diabetes Inpatient Audit. If resources allow, the specialty will look to take part in the future.
**** Limited resources identified within the Trust by Regional Parkinson's Disease Society and so data collection undertaken by North Tees/Northumbria Hospitals. Trust to take part in future audit if possible
***** Failed to register to participate

National Confidential Enquiries Programme 2010/11			
Confidential Enquiry	**Eligible for participation**	**Participation**	**Compliance**
Peri-Operative Care (NCEPOD*)	☑	☑	100%
National Head Injury (NCEPOD / CEMACH**)	☑	☑	100%
Surgery in Children (NCEPOD)	☑	☑	100%
Cardiac Arrest Procedures (NCEPOD)	☑	☑	100%
Perinatal mortality (CEMACH)	☑	☑	100%
NCISH ***	N/A	N/A	N/A

* National Confidential Enquiry into Patient Outcome and Death (**NCEPOD**)
** Confidential Enquiry into Maternal and Child Health (CEMACH)
*** National Confidential Inquiry into suicide and homicide by people with mental illness (NCISH)

The reports of 10 national clinical audits were reviewed by the provider in 2010/11 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

- **National Sentinel Audit of Stroke:** Stroke patients are now admitted to the new Stroke Unit which has 12 single rooms and six 4 bedded areas with en suite facilities. The unit has a dedicated Therapy Suite and a 24 hour, 7 day thrombolysis service which is supported by telemedicine. New consultant rotas have also been established to deliver the new service. Continued progress in staff education of stroke/transient

ischaemic attack (TIA) assessment with 3 consultants and 2 specialist nurses now trained as trainers in order that all staff can now undergo training on site.

- **National Audit of Continence Care:** Following the results from the audit which highlighted the need for routine collection of continence assessment tools, an electronic assessment tool has been developed on the hospital's information support system (HISS) for use by all staff for all inpatient admissions.

- **National Hip Fracture Database:** Changes in practice include orthogeriatrician shared care and planned weekend cover, multidisciplinary mortality and morbidity meetings with the Care of the Elderly specialty and Anaesthetists. There are also planned changes to the trauma list to help facilitate early intervention.

- **Audit of Familial Hypercholesterolaemia (FH)**: Work is underway to develop regional guidelines for the management of FH through the Northern Region Lipid Specialists Clinical Advisory Group which is part of the Northern Region Cardiovascular Network. Longer term funding arrangements are being pursued for the cardiac Genetic Specialist Nurse to continue to undertake cascade testing of relatives of patients who have FH.

- **National Diabetes Inpatient Audit**: Participation in the audit provided the impetus to join the national 'Think Glucose' campaign, the aim of which is to improve the quality and safety of care of patients with diabetes admitted to hospital. Insulin safety is being improved through enhanced staff education, patient self-administration and electronic prescribing of insulin linked with point of care technology.

Local Clinical Audit

The reports of 184 local clinical audits registered with the Clinical Governance department were reviewed by the provider in 2010/11 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

- **Stroke service:** Following an audit of antithrombotic medication, the Stroke Team has developed patient group directives whereby nursing staff are able to administer the first dose of aspirin after brain imaging has excluded haemorrhage.

- **Emergency Department:** The department established an alcohol audit which looked at alcohol related attendances in the department. Data from the audit provided evidence to support the implementation of a hospital alcohol team. The hospital team consists of a lead consultant, alcohol liaison specialist nurse, brief interventions team and youth worker for adolescents.

- **Neurology:** Reviewing the reasons for readmission of Parkinson's patients has led to a formally agreed set of criteria for earlier involvement of palliative care. This was shared with local GPs to enable patients to be added to the Community Palliative Care Register earlier in the course of their disease. Crucially, the criteria also include other long term neurological conditions such as MS and epilepsy in line with recommendations from the National Service Framework (NSF) for Long Term Conditions.

- **Care of the Elderly:** Following an audit of oxygen prescription, Matrons now undertake regular spot checks to ensure oxygen is correctly prescribed with a recommendation to the Oxygen Prescribing Group that the patient's target saturation levels are recorded on the Early Warning Score chart.

- **Podiatry (chiropody):** Communication between the wards and the podiatry department has improved greatly following an audit of pressure ulcers of the heels. Referrals for podiatry advice on the prevention and management of heel ulcers are now made much quicker and outcomes are improving. A number of educational sessions for staff have also been facilitated by podiatrists.

- **Physiotherapy:** Many patients are not aware of the potential benefits of their physiotherapy. Following a recent audit, letters which are sent out to patients now explain the potential outcomes of physiotherapy prior to their first appointment.

- **Neurology:** An audit of epilepsy patients who present at the clinic without a witness to their seizures has prompted an alteration to the appointment letters for this patient group. The letter will now include a request for their witness to accompany them to clinic.

- **Renal:** An audit of the increased patient flow from general nephrology clinics to low clearance clinics in renal medicine has prompted the development of a comprehensive education booklet for this type of patient. The booklet contains information on Erythropoietin (EPO), dialysis and other specific services and also contains all contact numbers the patient will need. An education room in the Renal Department is also under development to accommodate the patient's first contact with the low clearance service.

Information on Participation in Clinical Research

Recognising the importance of research in helping the NHS to improve both the quality of care and future health of the nation, City Hospitals Sunderland, in line with Department of Health strategy is committed to supporting high quality research. As such the department is working towards incorporating the aims of the National Institute for Health Research, Department of Health Research Service Support Units Framework, and recommendations of the recent Academy of Medical Sciences Review, which broadly includes widening access to research, increasing the rate and speed of recruitment, streamlining the approvals system, strengthening industry collaboration and improving integration in clinical care. The Trust has succeeded in engendering key working partnerships with Clinical Directors, Directorate General Managers, Finance, HR, Pharmacy, Nursing and Quality, Clinical Governance, and Support Departments, to ensure that a strong research culture is embedded throughout the Trust.

Participation in clinical research demonstrates the commitment of City Hospitals Sunderland in improving the quality of care we offer and in making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by City Hospitals Sunderland in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 740.

Commitment to Research as a Driver for Improving the Quality of Care and Patient Experience

There are currently 198 studies registered at City Hospitals Sunderland, of which 12 are commercial. City Hospitals Sunderland has developed a well-balanced portfolio across specialties. Our engagement with clinical research also demonstrates the commitment of City Hospitals Sunderland to testing and offering the latest medical treatments and techniques.

In aligning research priorities with research partners, regular formal communication has been established with the Topic Specific Networks including, Diabetes, Stroke, Cancer, Neurodegenerative Disorders and Primary Care Research Networks, Medicines for Children and Mental Health Research Networks together with the Comprehensive Local Research Network in the co-ordination of a research infrastructure which is fit for purpose and enables all staff to participate fully in the research process.

For the reporting period 2010/11, 35 papers resulting from our involvement in NIHR research have been published demonstrating our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Information on the Use of the Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of City Hospitals Sunderland income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between City Hospitals Sunderland and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at:

http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

For 2010/11, approximately £3.5m of income was attached to the delivery of quality improvements through the CQUIN framework. The Trust achieved the majority of the set goals and has received approximately 90% of CQUIN monies.

The full CQUIN scheme 2010/11 and where we have achieved our targets are highlighted overleaf:

No.	Description of Goal	Indicator	Priority	Weighting	Achievement of target
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	VTE Risk Assessment	Nationally mandated	10%	
2a	Improve responsiveness to personal needs of patients	Composite indicator on responsiveness to personal needs from the Adult Inpatient Survey	Nationally mandated	5%	
2b		Management of pain & hospital food	Local	5%	
3	Improve outcomes for patients who have had a stroke	Stroke bundle of care	Regional	15%	
4a	Improve maternity care and increase breastfeeding	Increase the proportion of women that initiate breastfeeding	Regional	2%	
4b		% referred to stop smoking services and receive intervention	Regional	1%	
4c		% of births that are Caesarean section delivery (PCT derived)	Regional	2%	
5a	Reduce damage as a result of preventable pressure ulcers	Hospital acquired pressure sores (≥ grade 2)	Regional	5%	
5b		Pressure ulcers that deteriorate	Regional	5%	
6a	Reduce harm caused by falls	% patients with risk assessment completed within 24 hours	Regional	0%	
6b		% of patients with high risk score that have documented care plan	Regional	5%	
7a	Improve End of Life Care	Proportion of eligible wards using the Liverpool Care Pathway (LCP)	Regional	1%	
7b		Number of patients on LCP as proportion of those expected to die	Regional	2%	
7c		Completeness of LCP documentation	Regional	2%	
8	Monitoring and implementation of the full quality schedule	Completion of agreed audits and implementation of related action plans	Local	10%	
9	Implementation of newly designed pathways linked to reform priorities	Acutely ill/injured children – implement-ation of the Paediatric Short Stay Assessment Unit (PSSAU) and working towards an enhanced Children's Community Nursing Team	Local	5%	
10a	Accurate diagnosis and effective treatment of heart failure	% of Echocardiograms performed		5%	
10b		% of drugs (ACE/ARB) prescribed or documented as a contraindication for the	Local		

No.	Description of Goal	Indicator	Priority	Weighting	Achievement of target
		treatment of hypertension			
10c		% Beta blocker prescribed or documented as a contraindication			
10d		% Follow up arranged in heart failure service			
10e		% Heart failure bundle			
11	Cardiac rehabilitation	% patients accessing Cardiac rehabilitation - phase 3	Local	5%	
12a	Improve support to smokers to stop smoking	% smoking status is recorded	Local	2%	
12b		% of smokers referred to stop smoking service	Local	3%	
13	Improve safety of patient discharge	% of discharge summaries that include documentation of changes in medication and the reasons why	Local	5%	
14a	Improve access for patients	% of Choose and Book slot unavailability	Local	3%	
14b		Implement innovative ways of reducing Did Not Attend (DNA) rates. Payment linked to implementation of action plans but DNA rates will be monitored to assess impact.	local	2%	

Note:

- **Red indicates more than two quarters, out of four not being achieved**
- **Amber indicates two quarters or less, out of four not being achieved**

Information Relating to Registration with the Care Quality Commission and Periodic/Special Reviews

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

Activities that the Trust is registered to carry out	Status	Conditions applied
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 2010/2011.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Information on the Quality of Data

The Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 99.9% for out patient care; and
- 98.3% for accident and emergency care.

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

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

Information Governance Toolkit Attainment Levels

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

The final submission of the Toolkit had to be made by the 31 March 2011. City Hospitals Sunderland Information Governance Assessment Report overall score for 2010/11 was 80% and was graded green (satisfactory).

Clinical Coding Error Rate

City Hospitals Sunderland was not subject to the Payment by Results clinical coding audit by the Audit Commission during 2010/11. However as part of Information Governance Toolkit requirements the Trust had an external clinical coding audit, carried out by Connecting for Health registered auditors. The audit looked at 200 patient records across four specialties; Ophthalmology, General Surgery, Care of the Elderly and Paediatrics for discharges between 1st December - 31st December 2010.

The tables below show the percentage of correct coding, which highlights how accurate each case has been coded according to national data definitions;

Overall	Primary diagnosis	Secondary diagnosis	Primary procedure	Secondary procedure
City Hospitals Sunderland	96%	91%	99%	97%
IG 505 level 2 attainment requirement	90%	80%	90%	80%
IG 505 level 3 attainment requirement	95%	90%	95%	90%

Speciality level	Primary diagnosis	Secondary diagnosis	Primary procedure	Secondary procedure
Ophthalmology	92%	94%	100%	99%
General Surgery	96%	74%	100%	96%
COE	98%	97%	90%	91%
Paediatrics	98%	92%	100%	90%

There were 5 (2.5%) episode changes in the sample audited. The coding inaccuracy rate of 2.5% is much lower than the national 2009/10 average error rate of 11 % as identified in the Payments by Results Audit Data Assurance framework. Please note that the results should not be extrapolated further than the actual sample audited. The auditors described the overall findings as "*excellent*" and highlighted the following good practice areas:

- the Trust's commitment to data quality through positively encouraging clinical coders to attain the national qualification,
- the importance of an approved clinical coding trainer on site,
- the "excellent presentation of their patient case notes", and
- the good working relationship between the coding team and the clinicians.

A number of minor recommendations were also made to assist the Trust in the maintenance and further improvement of the quality of coded data.

The Trust Will be Taking the Following Actions to Improve Data Quality

Accident and Emergency

For Accident and Emergency the introduction of new quality standards and the importance of accurate data for Payment by Results require the Trust to focus on improving data quality within A&E. The new quality standards focus on:

- overall time in A&E
- time to initial assessment for patients arriving by ambulance
- time to treatment from arrival
- percentage of patients who left the department without being seen; and
- percentage of patients who re-attend A&E (unplanned) within 7 days of original attendance

The Trust's Data Quality department will work with the A&E team to improve the recording of key data to improve the accuracy of the indicators outlined above. This will include making the electronic dictionaries easier for staff to use and trialling a paperless system. These actions should be complete by the end of September 2012.

Small Systems

The Trust has recently expanded the Data Quality Policy to include departmental small systems (those areas that do not use the hospitals main system – HISS). A key area of work to be completed by the end of 2011/12 is to review the accuracy of the data held in these systems and set up a programme of checks and audits to improve the accuracy of data held within them if required.

Part 3: Other Information – Review of Quality Performance in 2010/11

We continue to be a high performing Trust and have developed a wide range of initiatives to improve quality of care, safety and patient experience. In this part of the report we review and provide examples of how individual services and specialties are focused on driving up quality.

Patient safety measures	07/08	08/09	09/10	10/11	National average / Peer Group
1. Patients with blood borne MRSA infection	37 (22*)	33 (25*)	20 (20*)	3~ (8*~)	N/A
Lower value indicates better performance Data source - MRSA data reported to the Health Protection Agency – using standard national definitions					
2. Patients with *C- difficile* infection (*post 72 hours cases)*	N/A	192 (270*)	93 (210*)	49 (98*)	N/A
Lower value indicates better performance Data source - C. *difficile* data reported to the Health Protection Agency – using standard national definitions					
3. Clinical incidents reported per 100 admissions	N/A	2.89	5.2	N/A#	
Organisations that report more incidents usually have a better and more effective safety culture Data source – National Patient Safety Agency					

* target for each year
~ target and actual performance relates to hospital acquired only, whereas previous targets and actuals were combined hospital and community acquired
# format of report and data no longer available from the National Patient Safety Agency

Rationale – Patient Safety measures
Reducing infections, either MRSA or *C.Difficile* has a clear impact in terms of patient safety. Less infections mean less complications for patients and improves their chance of a full recovery. More detailed information on these two areas are highlighted in Part 1 of this report, but the Trust is pleased to report that significant reductions in infections were recorded in 2010/11.

Organisations that report more incidents usually have a better and more effective safety culture. City Hospitals is committed to creating an open culture, where staff report incidents so learning can take place and where changes in practice to improve patient safety are implemented. It is unfortunate that the data is no longer available from the National Patient Safety Agency (NPSA), so the Trust cannot report how we have performed in this area during 2010/11.

Clinical effectiveness measures	07/08	08/09	09/10	10/11	National average / Peer Group
4. Hospital Mortality Risk Adjusted Mortality Index (RAMI)	81	84	82	80**	Peer 75**
Lower value indicates better performance Data source – CHKS 'Signpost' system (April 2010 – March 2011)					
** updated version of RAMI (RAMI 2010) – each year the rate is re-based					
5. Readmission rates (28 days)	6.0%	6.3%	6.5%	6.1%	6.3%
Lower % indicates better performance Data source - CHKS 'Signpost' system using 30-day re-admission standard national definition					
6. Patients with fractured neck of femur operated on within 24 hours of admission	83%	83%	82.3%	83.3	N/A
Higher % indicates better performance Data source - internal Trust data (April 2010 – March 2011)					

Rationale – Clinical Effectiveness measures

Reducing mortality is extremely ambitious given the range of factors involved. However, City Hospitals is committed to improving practice wherever possible in order to reduce the Trust's mortality index. This is explained further under Mortality within Section 3.

Readmissions (where a patient is readmitted to hospital following a recent discharge) will always take place for very good clinical reasons. However, reducing readmission rates to the lowest possible level ensures patients are getting the right treatment, both in and outside hospital after their initial discharge and it is pleasing to note that readmissions during 2010/11 reduced to 6.1%, significantly lower than our peer group, which reported 7.0%

When patients fracture their hip (fractured neck of femur) it is important they are operated on as quickly as possible as this has clear links to an improved outcome. The Trust is therefore determined to ensure that the majority of patients are operated on within 24 hours. For 2010/11 83.3% of patients were operated on within 24 hours, a slight improvement compared to the previous year.

Patient experience measures	2007	Best 20%	2008	Best 20%	2009	Best 20%	2010	Best 20%
7. Patients who felt they were treated with dignity and respect	88	90	89	90	88	90	90	90
Higher scores indicates better performance Data source – Annual Inpatient Survey 2010								
8. Patients involved as much as they wanted to be in decisions about their care	71	73	73	74	71	74	74	74
Higher scores indicates better performance Data source – Annual Inpatient Survey 2010								

Patient experience measures	2007	Best 20%	2008	Best 20%	2009	Best 20%	2010	Best 20%
9. How patients rated their overall experience	77	80	77	81	77	81	80	81

Higher scores indicates better performance
Data source – Annual Inpatient Survey 2010

Rationale – Patient Experience measures
All of the indicators highlighted above show the Trust is committed to improving the patient experience. Governors and other key stakeholders have told us the importance of treating patients with dignity and respect and for patients to be involved in decisions about their care. This is why along with the patients overall experience the Trust's aim was to be in the Top 20% of all Trusts, a target which was achieved for 2 out of the 3 areas listed above.

Focus on Quality and Improvement

The following examples show our performance in the three dimensions of quality; patient safety, clinical effectiveness and patient experience.

Quality Dimension 1 - Focusing on Patient Safety

Dr Foster Hospital Guide 2010

Dr Foster is an independent provider of comparative information on healthcare services. Their Good Hospital Guide, published in November 2010, is a public document open to scrutiny by government agencies, healthcare providers, patients and the media. It has a strong focus on safety and uses safety measure data derived from a number of sources (including Trusts themselves through self assessment) to show how a hospital is performing on a range of safety indicators, ie mortality, safe environment and avoiding harm, recovery from ill health or injury.

The Good Hospital Guide did identify that care provided by City Hospitals Sunderland is generally of a high standard in the mortality and patient safety areas that were reported. Our performance for the majority of the indicators was 'in line with expected'. In terms of notable performance, we achieved a low rating (a green, 'better than expected' score) for the safety indicators pulmonary embolism and post-operative respiratory failure.

However, the Good Hospital Guide did report that the overall Hospital Standardised Mortality Ratio (HSMR) was higher than expected (114). There are several ways in which HSMR can be calculated. City Hospitals uses another company called CHKS, which like Dr Foster provides information about a hospital's performance. It should be noted that CHKS uses an alternative mortality score called RAMI (Risk Adjusted Mortality Index). Using this method, hospital mortality at City Hospitals for the last year was below average. (See Mortality section later).

Patient Safety First

During the week 15th – 19th November 2010, which was designated 'Patient Safety Week' by the national Patients Safety First campaign, City Hospitals announced a series of initiatives to raise awareness locally about their commitment to patient safety. Some of the activities that took place included:

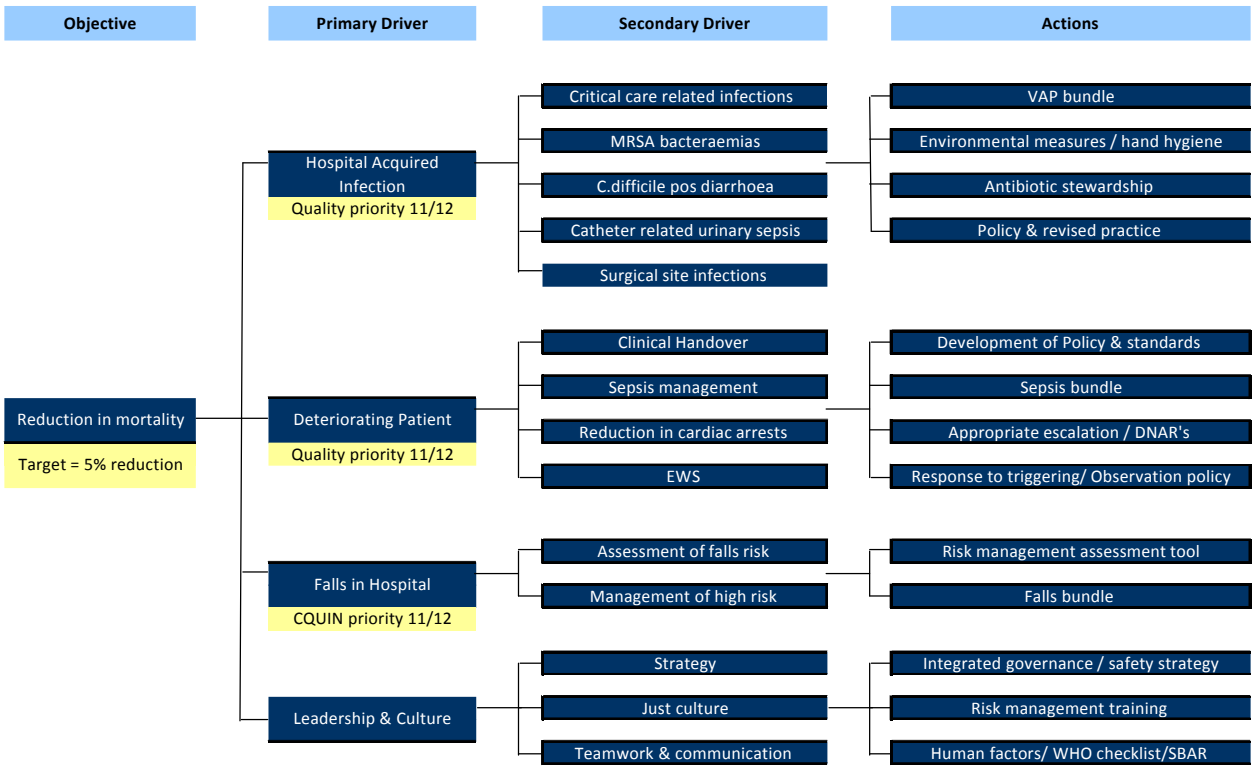
- A Hand Hygiene stall available to staff, patients and visitors in the main concourse foyer,
- A series of Patient Safety Clinical Audits which focused on key topics such as patient observation/early warning scores, fluid balance charts and pressure ulcers,
- A Patient Safety Resource display which was available in the library throughout the week.
- A drop-in patient safety incident reporting clinic for staff to help them understand the Trust's Incident Reporting process.

The Executive Team also undertook a series of leadership walkabouts with Matrons, to meet patients and staff and to discuss issues of patient safety across the Trust.

Leading Improvements in Patient Safety (LIPS)

In January 2011, the Trust completed the supervised parts of the national Leading Improvements in Patient Safety (LIPS) programme. The programme aims to help Trusts to develop plans for enhancing patient safety and to give staff the tools, skills and passion to drive improvements at every level of the organisation. Our overarching aim within the programme was to reduce mortality. The illustration below highlights the 'drivers' or key areas of improvement which we will build on in 2011/12.

Reduction in mortality 'driver' diagram



Clinical Alerts - Emergency Readmission Following Appendectomy

Information about the outcomes of services in NHS Trusts is monitored by the Care Quality Commission. If its collective data sources suggests a reason for review or further investigation for assurance purposes they alert the Trust.

In December 2010 the Trust was notified by the Care Quality Commission that analysis undertaken by them had indicated significantly high rates of emergency readmissions within 28 days of discharge following emergency admission for '*Appendectomy procedures aged under 70 without complications or co-morbidities'*. Our investigation of records found no evidence of poor patient management but there were improvements needed in completion of discharge communication and around clinical coding.

The Care Quality Commission accepted our report and its findings and the alert is now closed.

Quality Dimension 2 - Focusing on Patient Experience

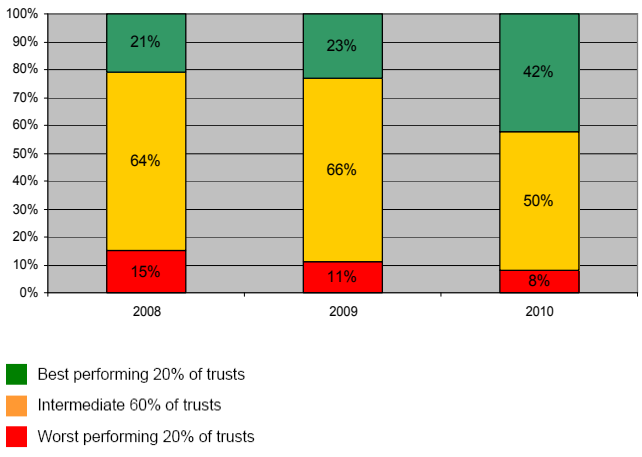
The NHS Inpatient Survey

As part of the Care Quality Commission's 8th inpatient survey published in April 2011, patients were asked to give their views on the service they received from City Hospitals Sunderland. It is one of the largest surveys of patient experience in hospital undertaken in the UK. The questionnaire covered a range of topics from hospital food, cleanliness, and levels of privacy to communication with staff, discharge planning and overall quality of care. Questionnaires were posted to 850 people, of which 429 were returned, giving a response rate of 51% (national rate was 50%).

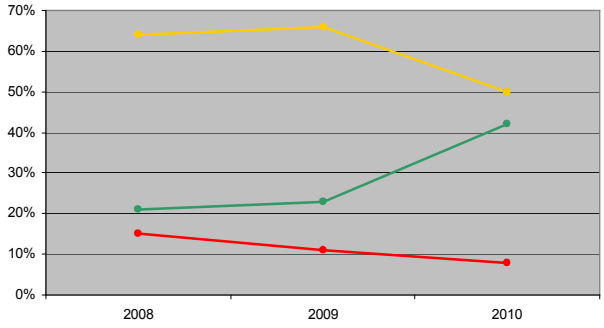
Did we do any better than last year?

Results from the 2010 survey show that patients are rating their hospital stay more highly than in previous years, with the number of red scores continuing to decline (15%, 11% & 8% over the last 3 years) and green scores (42%) almost doubling compared to last year (23%).

Distribution of category ratings for surveys 2008-2010



Trends of category ratings for surveys 2008-2010



Scores achieved in the green category (best performing 20% of trusts)

Survey questions – comparison of 2009 and 2010 results		2009	2010	
Q3.	How much information about your condition did you get in the A&E Department?	83%	89%	☑
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	87%	91%	☑
Q5.	How long did you wait from arriving at A&E to be admitted to a bed on a ward?	71%	68%	☒
Q12.	Upon arrival, did you feel that you had to wait a long time to get to a bed on a ward?	81%	85%	☑
Q20.	Were you ever bothered by noise at night from other patients?	65%	67%	☑
Q21.	Were you ever bothered by noise at night from hospital staff?	83%	85%	☑
Q26.	Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels?	99%	99%	**No change**
Q27.	Were hand-wash gels available for patients and visitors to use?	97%	98%	☑
Q32.	Did you have confidence and trust in the doctors treating you?	90%	92%	☑
Q34.	As far as you know, did doctors wash or clean their hands between touching patients?	86%	88%	☑
Q36.	Did you have confidence and trust in the nurses treating you?	86%	88%	☑
Q39.	As far as you know, did nurses wash or clean their hands between touching patients?	87%	90%	☑
Q40.	Did a member of staff say one thing and another say something different?	80%	81%	☑
Q41.	Were you involved as much as you wanted to be in decisions about your care?	71%	74%	☑
Q42.	How much information about your condition or treatment was given to you?	79%	82%	☑
Q56.	Did the anaesthetist explain how he or she would put you to sleep or control your pain?	94%	94%	**No change**
Q57.	Afterwards, did a member of staff explain how the operation or procedure had gone?	77%	81%	☑
Q60.	What was the main reason for the delay?	67%	75%	☑
Q61.	How long was the delay to discharge?	80%	86%	☑
Q63.	Did hospital staff explain the purpose of the medicines you were to take home?	86%	87%	☑
Q64.	Did a member of staff tell you about medication side effects to watch for?	51%	52%	☑
Q65.	Were you told how to take your medication in a way you could understand?	84%	89%	☑
Q66.	Were you given clear written information about your medicines?	79%	80%	☑
Q67.	Did a member of staff tell you about any danger signals you should watch for?	52%	59%	☑
Q72.	Did you feel you were treated with respect and dignity while you were in hospital?	88%	90%	☑
Q73.	How would you rate how well the doctors and nurses worked together?	79%	80%	☑

Survey questions – comparison of 2009 and 2010 results		2009	2010	
Q76.	Did you see any posters or leaflets explaining how to complain about the care you received?	49%	56%	☑

☑ - Higher score than last year
☒ - Lower score than last year
No change – score same as last year

Scores achieved in the red category (Worst 20% of trusts) - Where we still need to improve

Survey questions – comparison of 2009 and 2010 results		2009	2010	
Q11	Was your admission date changed by the hospital?	93%	90%	☒
Q19.	Did you ever use the same bathroom or shower area as patient of the opposite sex?	79%	75%	☒
Q29	Were you offered a choice of food?	75%	83%	☑
Q45	Were you given enough privacy when discussing your condition or treatment?	80%	79%	☒
Q48	Do you think the hospital staff did everything they could to help control your pain?	80%	79%	☒

☑ - Higher score than last year
☒ - Lower score than last year
No change – score same as last year

These issues have been recognised as areas for improvement and actions are highlighted in Part 1 of this report within the Priority 2 section.

Real Time Feedback

Our real time patient feedback system complements our participation in the national patient surveys and together they provide useful insights into the patient experience in hospital.

Real time feedback is a new way of finding out what patients think about their stay in hospital and involves patients completing a short questionnaire whilst still on the ward and ready for discharge. The system started in August 2010 and is unique in that it is driven by a network of lay groups, volunteers and governors. They visit the wards and invite patients to complete the questionnaire, offering help where needed. Since the start of the programme the Trust has received and analysed 1365 questionnaires as well as reporting an additional 301 patient comments (190 negative and 111 positive) from 26 participating wards.

What were patients happy about?

The 'best performing' questions were around patients having adequate storage facilities for belongings (average 98%), the cleanliness and tidiness of wards (97%), staff washing their hands (96%) and patients feeling safe during their stay (96%). The most positive patient comments received related to 'overall patient experience' (No=51) and the politeness and professionalism of hospital staff (37).

What do patients want us to improve?

The 'worst performing' questions concern choice of hospital food (average 77%) and explanation of medication side effects (75%), with negative comments reflecting issues concerning choice of food and the perception by patients of their lack of involvement in decisions about their care.

What improvements have we made?

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

- Introduction of 2.00pm 'ward rounds' where nursing staff visit each patient and relative to give an update on care;
- Use of daily 'POWOW' patient discussion groups at 10am to talk about aspects of discharge;
- A qualified nurse now coordinates mealtimes and ensures that the food is presented well, hot, and that all patients are offered a choice. If there is nothing on the menu that patients like, they will be informed of alternatives;
- Meal trolleys are taken into bays so patients can view what meals are available;
- Matron monthly audits looking at aspects of the environment;
- A ward pharmacist now discusses medication with patients as a matter of routine;
- Increased frequency of checks by domestics to ensure that the toilets are clean at all times;
- Extending the involvement of volunteers, ie hair, nails, sitting, befriending patients.

Future improvements to the real time feedback collection

For 2011/12 we will continue to develop our real time feedback systems with the following plans:

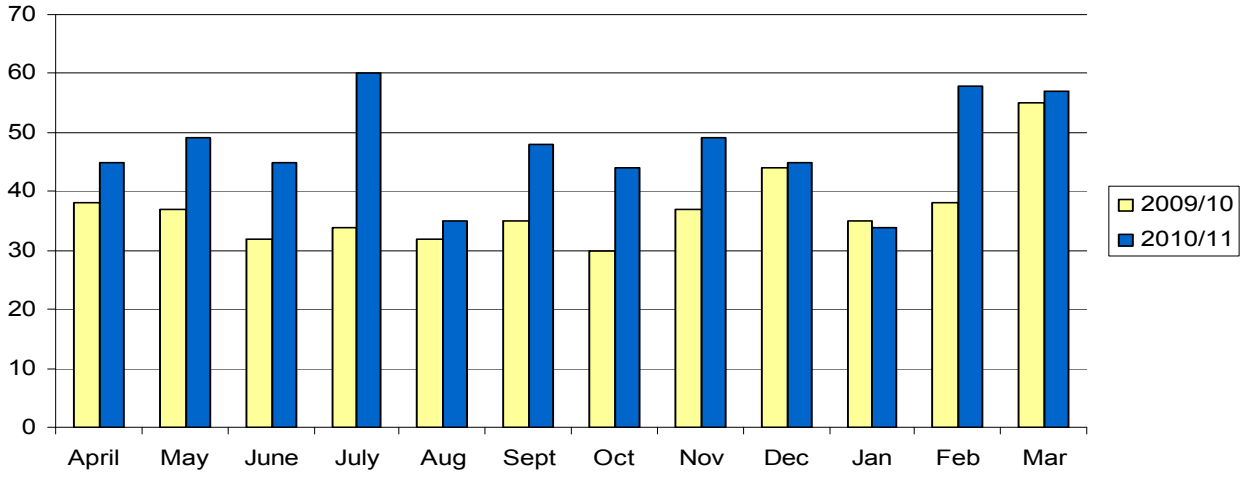
- To expand the pool of volunteers so that we can cover more wards and speak with more patients about their experiences;
- To expand the scope of patient feedback and include areas such as Maternity and children's wards. In addition we will look to consider some of the therapy outpatient clinics;
- To design a series of posters to show patients and the public that we have listened and to show what difference their personal experiences have made. These 'What We Have Done' posters will be placed in highly visible, high volume patient areas so that as many people as possible can see the changes that have been made. Where we are unable to make those changes, we will provide a reason why not;
- The outcomes will be linked to the re-launching of the 'Listening to Patients' comment boxes.

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.

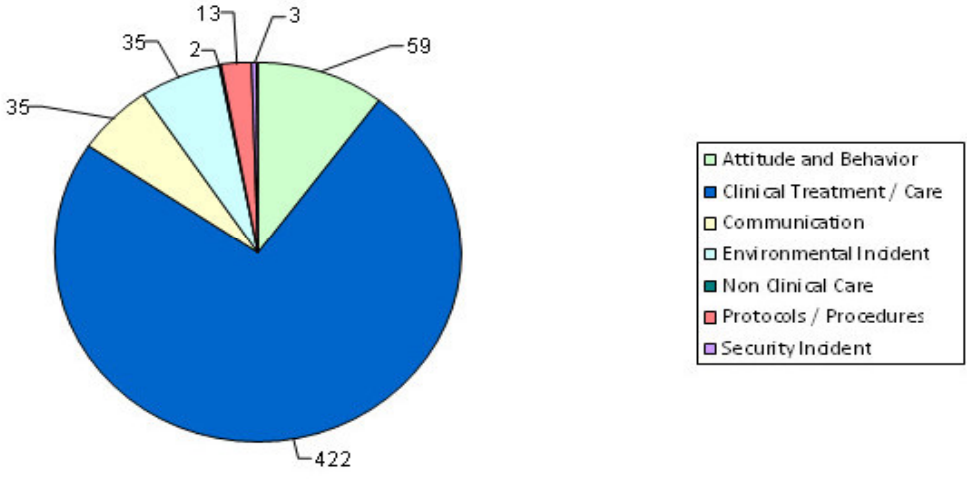
During 2010/11 the Trust received 568 formal complaints from patients or their representatives. This represents a 27% increase compared to last year. The chart below shows the distribution of complaints received each month for the current and previous year.

Comparison of complaints activity 2009/10 and 2010/11



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

Complaints activity by corporate theme 2010/11



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 recurrence. The following examples highlight where we have made changes to practice as a result of complaints:

- Introduction of bereavement cards to send to families of patients who have passed away on Care of the Elderly wards. The card offers condolences but also provides contact details if they have any unanswered questions;
- Introduction of self check-in kiosks in Chester Wing and Physiotherapy to speed up and simplify the booking in process for patients and avoid queuing at reception desks;
- Patients automatically receive a copy of clinic correspondence with GP, unless they express not to receive information;
- Improvements have been made to written communication in relation to outpatient appointments and cancellations. Further improvements planned in 2011/12 to standardise all outpatient letters;
- A dedicated pharmacist has been allocated to Acute Medical Unit (AMU) who controls and manages medications and discusses accordingly with patients;
- Renovation of the bathroom on the cardiology ward. The bath has been removed and replaced with a shower to allow easier access for patients;
- Provision of evening clinics in dietetics for those patients who have difficulty attending during working hours;
- Provision of privacy screens around the self check in kiosks within physiotherapy to protect patient confidentiality;
- Changes to guidelines within obstetrics in relation to patients requesting repeated analgesia in the ante natal period;
- Improved organisation of beds within Trauma and Orthopaedics to prevent patients being cancelled on the day of surgery where possible.

PEAT Inspections – Making Improvements to Ensure Our Hospitals are Safe and Clean

The annual Patient Environment Action Team (PEAT) inspection is a self assessment and inspection exercise which measures standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). It is designed to ensure that improvements are made in the non-clinical aspects of a patient's experience. As in previous years, the PEAT inspection process has involved Trust governor representatives and members of our Community Panel, in addition to senior nursing, catering and facilities staff.

NHS Trusts are given scores from 1 (unacceptable) to 5 (excellent) for standards of privacy and dignity, environment and food within their buildings. The results of the 2010 assessment compared with those achieved in 2009 are highlighted overleaf:

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

Privacy & Dignity – Our Commitment to Same 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.

At the end of 2010/2011, City Hospitals issued a compliance statement on these national standards and gave a commitment to eliminate mixed sex accommodation. We have undertaken a works programme to improve the patient environment to meet these standards. In addition we have revised our admissions and operational bed management policy to help us achieve the same sex standard. We continuously monitor the same sex standard via the Real Time Feedback system and report results each month directly to the Wards.

At the Standards of Care Event in June 2010 we presented the results of the 'Mixed Sex Wards Survey' undertaken by the Community Panel and restated the key message that it is not acceptable for patients of the opposite sex to share a sleeping area, bathroom or toilet on non-clinical grounds.

Reported Breaches of Same Sex Accommodation

Current performance against breaches of same sex demonstrates that where breaches have occurred, these have been clinically appropriate due to the patient being in a life threatening phase of their condition, ie first few hours of a stroke or a suspected heart attack. However, the Trust is not complacent and tougher rules around same sex accommodation are now in place for other areas, outside of the normal ward environment. Any breaches of these new standards will be reported throughout 2011/12.

Quality Dimension 3 - Focusing on Clinical Effectiveness

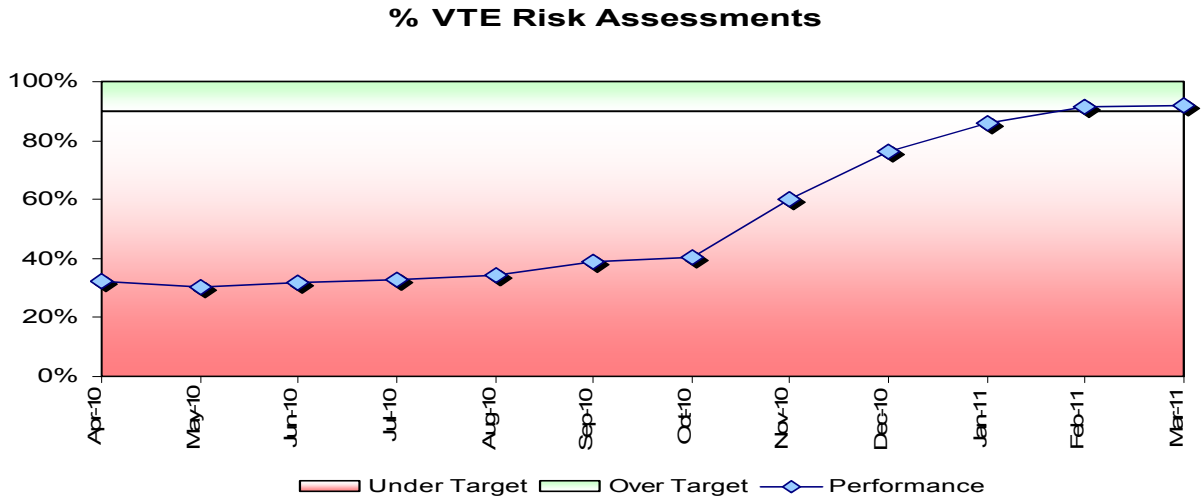
Venous Thromboembolism (VTE)

An estimated 25,000 people across the country die from preventable hospital acquired VTE every year. VTE refers to the formation of a thrombus (blood clot) within veins, which can occur anywhere in the body. The predominant sites are in the veins of the leg giving rise to deep vein thrombosis.

The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and other predisposing risks such as obesity. From 1 April 2010 a number of measures have been introduced across the NHS to help ensure a comprehensive National VTE Prevention Programme is in place for England. The

programme includes measures to ensure that every adult patient has a documented VTE risk assessment on admission to hospital.

The Trust has been working on improving the percentage of VTE risk assessments throughout the year (the CQUIN target was 90% by the end of the year) and we were able to achieve the target during February 2011. This has been a huge challenge and required significant changes to be made to our admission processes and data capture systems. The progress made over the year is shown in the chart overleaf.

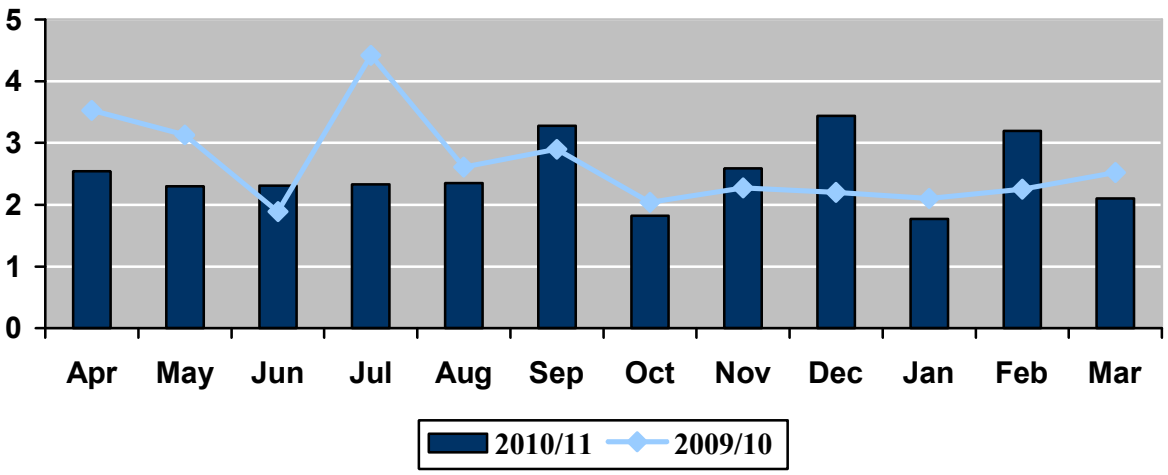


The prevention and management of VTE will again be part of the CQUIN scheme next year, and the target of 90% and above is expected to be achieved each month.

Pressure Ulcers – Reduction in the Incidence of Hospital Acquired Pressure Ulcers

Pressure ulcers represent a major burden for patients in terms of the impact on mobility and quality of life. As part of the Commissioning for Quality and Innovation (CQUIN) framework the Trust monitors the number of hospital acquired pressure ulcers graded 2 or more using the European Pressure Ulcer Advisory Panel (EPUAP) Classification System. The table overleaf illustrates the number of ulcers per 1000 bed days (against throughput).

Number of grade 2+ hospital acquired pressure ulcers per 1000 bed days (1/04/10 – 31/03/11)



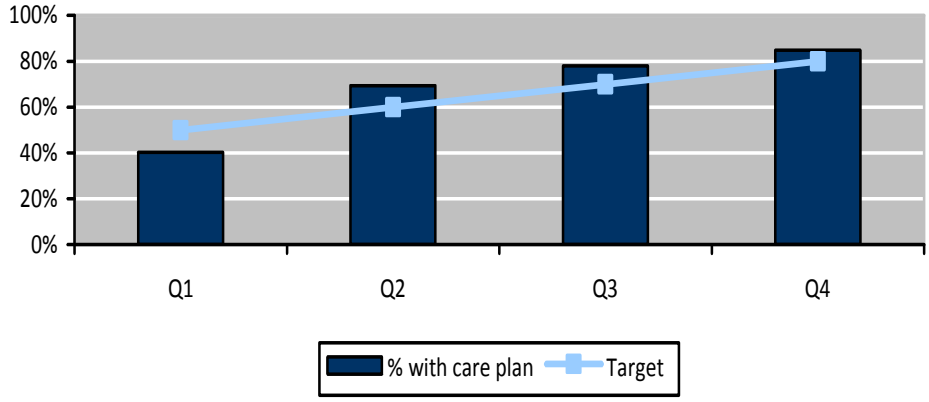
The picture of progress and reduction in hospital acquired pressure sores during the year has been mixed, but we have had some success, and we are confident that we can further improve practice in a number of areas. The Trust now has an action plan in place to improve the assessment and management of pressure ulcers, which is overseen by the multidisciplinary Tissue Viability Group. Some of the developments we are working on include:

- Revising the Trust Pressure Ulcer Prevention policy, which will establish clear standards, procedures and referral pathways for the prevention and treatment of pressure ulcers;
- Introduction of a pressure ulcer 'aide memoire' to help staff grade pressure ulcers; this will be launched at a Trust wide Tissue Viability event to be held in 2011;
- Reviewing the pressure ulcer care plan so that it reflects best practice;
- Preparing a business case for the funding of a tissue viability practitioner;
- Considering the potential of introducing a more flexible way of training staff using an e-learning educational package.

Falls Prevention and Management

Patient falls are common in hospital, particularly among the frail elderly. As part of the Commissioning for Quality and Innovation (CQUIN) framework's safety focus the Trust has been monitoring the number of patients who receive a Falls Risk Assessment and have a score of 15 or more (high risk of falling) to establish whether a care plan is put in place. The table below shows significant progress has been made.

% of adult inpatients with falls high risk score with care plan (1/04/10 – 31/03/11)



Improvements This Year

The Trust recently completed a region-wide audit of in-patient falls prevention (co-ordinated by Safer Care North East). We were able to respond positively to 39 of the 46 falls standards, and through the work of the Trust Falls Committee we intend to develop the following areas:

- Introduction of post-falls protocol in all wards areas,
- Improvements to the analysis and reporting of falls.

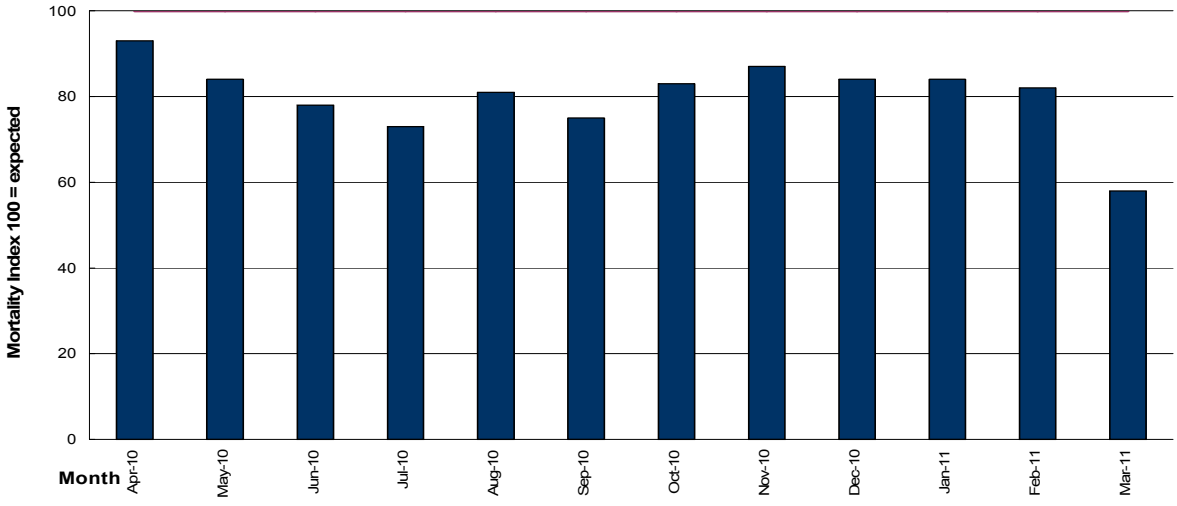
Mortality

Mortality rates are a key measure of a hospital's performance on clinical outcomes. The standard way of measuring mortality is using the Standardised Mortality Rate, or SMR. This is a measure that makes adjustments for how sick the patient is, the kind of treatment a hospital offers, the age of the patient and what their living conditions are like at home. For example a hospital treating generally healthy 25 year olds from a prosperous area and specialising in minor procedures, would be expected to have lower death rates than one performing complex operations on an ageing population in a socially deprived area.

After the adjustments to take account of all of the above, the results (the SMR) are reported as a ratio so that a perfectly average hospital would have an SMR of 100. An SMR greater than 100 suggests a higher than average mortality rate and less than 100 a better than average rate. There are other ways of measuring mortality rates, including the HSMR method used by Dr Foster. They all work slightly differently which can be very confusing, so that the Department of Health has asked a group of experts to develop a single agreed measure that will be used across the NHS.

At City Hospitals we use the CHKS tool and a mortality score called RAMI (Risk Adjusted Mortality Index). Using this method the SMR throughout 2010/11 shows there was less deaths than expected (100 being what is expected). It is not uncommon for the RAMI score to differ from the Dr Foster method, for example scores reported on NHS Choices show overall Hospital Standardised Mortality Ratio (HSMR) for City Hospitals to be higher than expected. However both CHKS and Dr Foster make it clear that mortality ratios on their own should not be used as the only indicator of performance. They should be used in conjunction with other measures of comparisons. The majority of Trusts in the North East now use the CHKS method for monitoring hospital death rates. The table below shows the monthly RAMI score:

Monthly hospital standardised mortality using the CHKS RAMI score



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Mortality	93	84	78	73	81	75	83	87	84	84	82	58
Expected	100	100	100	100	100	100	100	100	100	100	100	100

Planned Improvements for 2011/12

- Development of a new Trust-wide mortality monitoring and review policy, which will promote a structured way of reviewing and reporting on deaths;
- Ensure directorates have regular mortality meetings to share the learning from reviews of deaths with colleagues;
- Introduce a summative mortality scorecard for reporting to the Boards;
- Continue the developmental work within the Leading Improvements in Patient Safety (LIPS) programme.

During 2010, we received information from the Care Quality Commission about our hospital mortality. In November 2010 they asked the Trust to provide information and assurance around higher than expected death rates for patients who had been admitted with hepato-biliary disease, pancreatic disease, digestive and musculoskeletal conditions.

A comprehensive review of patient case notes was undertaken by relevant senior medical consultants. The audit found that the majority of deaths were regarded as being predictable given the patient's presentation and the presence of serious co-morbidities. In the majority of cases we were able to confirm correct and timely investigations and appropriate treatment. This conclusion has been reported back to the Care Quality Commission.

Releasing Time to Care (the 'Productive Ward')

The Time to Care programme helps teams to reorganise and redesign the way they manage and operate the workplace. The programme offers a way of getting the right things to the right place, at the right time, in the right quantities, whilst minimising waste and being flexible and open to change. It adopts many efficiency and safety techniques from industry and is known as LEAN thinking.

Simply by getting better organised our staff have been able to achieve significant improvements by increasing the amount of time nursing teams are able to give directly to patients, which in turn improves quality of care. The key to success is that improvements are driven by staff themselves – those best placed to see where improvements and efficiencies can be found. The process has also helped to make savings in materials and reduce waste, as well as improve staff morale, by helping staff to make positive changes in the workplace and get the most out of their role.

The Time to Care programme commenced in City Hospitals in December 2008, and we now have 35 wards engaged in the programme. Some of the changes that have taken place include:

- Wards now look clean, tidy and uncluttered, giving a professional feel,
- Improvements to layout and stock control mean that everything is in its place and 'ready to go',
- Patient bed boards have been re-designed to include a standardised layout with space to list 'special instructions' for patients,
- Introduction of electronic shift handover to improve communication among nurses between shifts,
- Streamlining of the patient meals process so that meals are delivered to wards quickly and ensuring that sufficient nurses are available to support patients,
- Introduction of 'Do Not Disturb' tabards for staff undertaking the medicines round to prevent unnecessary interruptions and maintain patient safety.

Other examples of how the Trust is using LEAN design to improve quality and service efficiency include**:**

- **Participating in enhanced recovery** – The aim of the programme is to improve patient outcomes and speed up a patient's recovery after surgery. It also focuses on making sure that patients are active participants in their own recovery process and receive care at the right time.

- **'Front of House' project** - LEAN methods were used to identify waste, non-value added steps and improvements within the Emergency Care pathways, ie Accident & Emergency and the acute admission units (Medicine & Surgery). Further work will continue in 2011 to re-design the Accident & Emergency Department to improve patient flow.

- **Operating Theatres** - Theatre preparation and storage rooms are now better organised with the correct stock and equipment, enabling theatre lists to run smoothly and reducing overruns.

- **Dementia Services** – local improvements include the holding of a lunch club for dementia patients, availability of 'therapeutic' reminiscence books and training in the use of the Mini Mental State Examination (30-point questionnaire test that is used to screen for cognitive impairment in dementia).

Making Improvements to Stroke Services

City Hospitals has been working hard to develop stroke services in line with the National Stroke Strategy. By changing the way we work, it has allowed us to develop better pathways for patients, more timely access to services and better quality of care for patients before and after discharge.

New Acute Stroke Unit (ASU)

The Acute Stroke Unit (ASU) has moved to a 40 bed facility in the new ward block on the Sunderland Royal site. The unit has dedicated and trained stroke nurses and therapy staff, who provide care and therapy within the ward area. This move will enable the Trust to achieve its objective of treating the majority of stroke patients on a dedicated acute stroke unit for most of their stay.

There is also an Acute Stroke Assessment Area (ASAA) within the Acute Medical Unit where the stroke team are pre-alerted by the North East Ambulance Service of any FAST positive patients (*Act F.A.S.T is a national awareness campaign aimed to educate healthcare professionals and the public on the signs of stroke and that prompt emergency treatment can reduce the risk of death and disability*). Patients are admitted directly to this area and assessed rapidly, to identify if the patient is suitable for thrombolysis treatment. The quicker this treatment is given the better the outcomes and recovery for patients. The existing thrombolysis service will be expanded and will be available 24 hours per day, 7 days a week.

In the ASAA patients are cared for by trained stroke nurses and receive therapy support from admission including swallowing assessment, mobility assessment and specialist nurse intervention, to ensure delivery of the highest possible quality of care. Following stabilisation, the patient is transferred directly to the ASU.

Rehabilitation

Once the acute phase of stroke care is complete, patients may undergo a period of rehabilitation in the ASU or discharged home with the Community Stroke Team for rehabilitation. The Community Stroke Rehabilitation Team (CSRT) was launched in September 2009 and stroke rehabilitation services are now more flexible, timely, and patient centred. The team offers high quality, domiciliary based rehabilitation and health promotion for patients who have recently suffered a stroke. The team has close links with hospital and community social services and patients are seen within 24 hours of referral (inpatients) and within 2 days of hospital discharge or community referral.

The service has resulted in the following benefits for patients:

- Seamless rehabilitation and nursing care following hospital discharge;
- Earlier hospital discharges;
- Improved outcomes for patients in communication, mobility, extended activities of daily living, return to work;
- Reduced risk of recurrence of cardiovascular disease,
- Timely and appropriate referrals to a vast range of services across outpatient therapies,
- Stroke Association services such as community integration and communication support, other voluntary sector organisations, carers' centre and exercise classes.

New Lithotripsy Service

The Urology Department at Sunderland Royal Hospital has introduced a new lithotripsy service based in the Urology Investigation Unit. The service offers convenient and effective treatment for kidney stones. Lithotripsy means 'breaking of stone'. It is the common term used for extra-corporeal shock wave lithotripsy (ESWL) which is a technique that uses shock waves to break up urinary stones within the kidney or ureter. Patients have previously had to travel to Newcastle for this procedure or undergo more invasive surgical procedures which are expensive to perform and result in an in-patient stay. Patients can now be treated in an out patient setting and go home a short while later. The procedure takes between 30 and 60 minutes to perform and no anaesthetic is required although pain relief and occasionally a sedative may be used if the patient experiences discomfort as the stone breaks.

Performance against key national priorities and patient targets

During 2010/11 the Trust delivered a number of significant performance improvements, all of which improved the quality of the service we provide to our patients. The Trust maintained its existing high levels of performance in a number of key areas such as inpatient and outpatient waiting times and further improved performance in a number of other areas such as cancer, stroke and healthcare acquired infections.

The table below highlights the key national priorities, with the majority taken from Monitor's compliance framework. Monitor, the regulator of Foundation Trusts produces a 'Governance' risk rating for each organisation and at the end of 2010/11, City Hospitals was rated 'Green', the highest rating possible.

Indicator	Last Year 2009/10	Target 2010/11	Actual 2010/11	Variance	Achieved
Quality/Safety Metrics					
Stroke Care - >=90% LOS on stroke unit*	60.04%	80.00%	82.66%	2.66%	●
Data quality on ethnic group	95.62%	90.00%	94.98%	4.98%	●
Maternity Data Quality	97.28%	90.00%	96.11%	6.11%	●
Delayed transfers of care	1.72%	<2.00%	1.76%	-0.24%	●
18 Week referral to treatment - admitted patients#	96.33%	90.00%	94.87%	4.87%	●
18 Week referral to treatment - non admitted patients#	99.11%	95.00%	98.50%	3.50%	●
Cancer waits - seen <=2 weeks from referral	93.76%	93.00%	93.39%	0.39%	●
Cancer waits - seen <=2 weeks from referral for breast symptoms	97.22%	93.00%	96.74%	3.74%	
Cancer - treated <=31 days	98.48%	96.00%	98.05%	2.05%	●
Cancer - subsequently treated <=31 days	98.85%	98.00%	99.11%	1.11%	
Cancer - treated <=62 days from referral	84.73%	85.00%	86.49%	1.49%	●
Cancer - treated <=62 days from screening	91.67%	90.00%	95.24%	5.24%	
A&E waits - admitted or discharged <4 hours	98.06%	95.00%	97.73%	2.73%	●
Cancelled operations - % total elective workload	0.53%	<=0.80%	0.47%	0.39%	●
MRSA screening	100%	100%	100%	0.00%	●
Incidence of BB MRSA	20	<8	3	-5	●
Incidence of C-DIFF	93	<98	49	-49	●

*Q4 performance, as target was to be achieved by the year end
March 2011 position

Cancer

At the end of 2009/10 the Trust narrowly missed achieving the government target of 85% for the 62 day target of referral to treatment. Improving this performance was a key priority for 2010/11 and it is pleasing to note for 2010/11 the Trust performance was 86.5%, above the required target, and more importantly meaning more patients got their required treatment quicker than in previous years.

All other cancer targets (2 week waits and 31 days from diagnosis to treatment) were achieved above the required standard for the year.

Accident & Emergency (A&E)

During 2010/11, the new coalition government and the Department of Health changed the targets in relation to A&E. The new expectation was for 95% of patients to been seen, discharged or admitted (if necessary) within 4 hours.

As anticipated the Trust experienced significant pressures from increased A&E attendances over the winter period and the Trust continues to receive more ambulances than any other A&E department in the region – around 600 per week. This places significant pressure on the department and the wider organisation and it is important we focus on this over the coming year to understand why Sunderland is different to the rest of the North East.

Working in collaboration with primary care the Trust ensured that 97.7% of patients were discharged or admitted within four hours of attending A&E or a local Urgent Care Centre during 2010/11. Looking ahead, a new expanded set of quality indicators for A&E are to be launched in 2011/12 and the Trust will work with our local partners to deliver these across the health community.

Stroke

Historically the Trust has struggled to achieve a number of the national stroke targets. However, 2010/11 saw a significant improvement in the quality of services we provide in this area. The team redesigned pathways to ensure patients were treated quicker and by the end of 2010/11 they achieved a number of objectives, including hitting the target of 80% (83.5% during Jan-Mar 2011) of patients spending 90% of their time on the stroke unit, compared to 60% last year.

Inpatients and Daycases

An internal priority for the organisation during 2010/11 was to reduce length of stay (LOS) in particular for non-elective (emergency) patients. This has been achieved, and the Trust used approximately 4,500 less bed days when compared to 2009/10. During the same period, the Trust also reduced the percentage of patients who were readmitted within 30 days from 6.5% to 6.1%, giving reassurance that patients are not discharged too quickly. The rate of 6.1% also compares very favourably with our peer group (a group of similar sized hospitals, serving a similar population), which for 2010/11 reported 7% of patients being readmitted.

The Trust continues to improve on the % of elective patients treated as a daycase. In 2010/11, this was 79.4% compared to 77.5% in 2009/10 and is 5% more than our peer group.

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

With respect to 18 weeks, the Trust once again achieved the required standard for both admitted and non-admitted patients.

Diagnostics

One of the organisations aims for 2010/11 was to reduce the time to taken to send a report back to a GP, once a patient had had their routine X-ray taken. The aim was to improve the service we offered to our patients and our GP colleagues. By the end of 2010/11 the Trust had significantly reduced the amount of time for a report to be produced, from 2 weeks to between 2-4 days and this position will be maintained in the future.

Control of Infection

The Trust achieved both national targets for MRSA and *C.difficile.* Further information on both these targets can be found within Part 1 of the Quality Report.

Statement from Lead Commissioner: Sunderland Teaching Primary Care Trust

NHS South of Tyne and Wear (serving Gateshead, South Tyneside and Sunderland PCTs) aims to commission safe and effective services that provide a positive experience for patients and carers. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. NHS South of Tyne and Wear takes this responsibility very seriously and considers this to be an essential component of the commissioning function.

Throughout 2010/11 NHS South of Tyne and Wear had monthly quality and contract review meetings with City Hospitals Sunderland NHS Foundation Trust. The mechanisms in place with local foundation trusts to monitor the quality of the services provided and to encourage continuous quality improvement are well established. The purpose of the quality review 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 eg Incident and Complaints reports
- review and discuss relevant external reports eg Care Quality Commission patient surveys
- monitor action plans arising from the above

In addition to the above a Non-Executive Director from Sunderland Teaching PCT takes part in infection control visits at City Hospitals Sunderland NHS Foundation Trust.

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

- timeliness of X-ray reporting to GPs,
- care of stroke patients,
- development of real-time feedback from patients using the community panel and trust volunteers,
- pressure ulcers,
- improvement work linked to food undertaken together with the local authority.

The Trust experienced significant pressures within the Accident and Emergency Department during the winter months and following a review has instigated a number of actions to manage the system better for next winter.

It is positive that the priorities for 2011/12 have been identified with Governors and LINks and whilst they focus on strengthening the basics of healthcare there are also other improvement priorities for instance those with the 2011/12 CQUIN scheme.

Much of the information contained within this Quality Report is used as part of the quality monitoring process described above eg performance against locally agreed quality measures and achievement against CQUIN indicators. As required by the NHS Quality Reports' regulations NHS South of Tyne and Wear has taken reasonable steps to check the accuracy of this information and can confirm that it is believed to be correct.

Statement from Sunderland Local Involvement Network (LINk)

Sunderland Link welcomes the opportunity to comment on City Hospitals Sunderland's Quality Account 2010-2011. The report provides a comprehensive picture of the Trust's performance against a number of national quality standards and is very transparent in detailing areas for improvement as well as highlighting its successes. We note the continued and significant improvement in hospital acquired infection since 2008 and the Trust's determined efforts to reduce infection further. We share the Trusts disappointment that our City Hospital only achieved General level 1 accreditation under the Clinical Negligence Scheme for Trusts (CNST). We too hope that the Trust can implement the necessary improvements and realise its aim of achieving Level 2 accreditation by 2012.

The Trust has identified a number of important priorities which include improved analysis of patient complaints and feedback. As the public voice for the access and usability of Health & Social Care services, Sunderland LINk is very pleased that in setting this priority the Trust is fully recognising the significance of patient feedback.

During the 2010 – 2011 reporting period Sunderland LINk collaborated with Sunderland City Council's Health & Wellbeing Review Committee's report into Malnutrition and Dehydration in Hospitals which took an extensive look at the current systems and surveyed almost 100 patients. In addition, LINk undertook a number of additional surveys with patients in the hospital's outpatient clinics using 'Enter & View' volunteers to look at waiting times and communication. The Trust Secretary and her team cooperated fully in supporting these elements of external scrutiny and we look forward to continued collaboration, in particular supporting and contributing to the Trust's priorities around patient feedback.

Michael McNulty
Chair

Statement from Health and Well-Being Scrutiny Committee

Thank for you forwarding a copy of your draft Quality Report for 2010/11.

The Health and Well-Being Scrutiny Committee welcomes the opportunity to comment on this year's Quality Account although, as you will appreciate at this time of year the new scrutiny committee membership is not formalised until 18th May. Nevertheless, I have consulted informally with the incoming Chair and Vice-Chair and would make the following statement.

The Scrutiny Committee can confirm that the selected priorities for 2011/12 are in line with the preferences of the Committee. Following our review of malnutrition and dehydration in hospitals during 2010/11, the Scrutiny Committee particularly supports the improvement priority for a better patient experience in choice of food and assisting patients to eat.

The Committee notes however that, as with all the priorities identified, the achievement of improvements is to an extent reliant upon the realisation of dignity and respect for patients as underlying principles.

The Committee would emphasise that dignity and respect are not separate from the other improvement priorities but are fundamental to the care and treatment of patients. The published Quality Account should reflect that dignity and respect are key principles of the Human Rights Act. To ensure that the rights of individuals are upheld, the Trust may wish to consider a set of key principles of behaviour as a standard which could be incorporated into service planning, commissioning and delivery, processes, practices and professional education.

For example, the Committee notes the number of patient complaints during the year which are related to the attitude and behaviour of staff. An increased profile given to the importance of dignity and respect may be a useful contribution to addressing these patient concerns.

The Committee is pleased to note the continuing efforts to collect patient feedback, and perhaps more importantly, to use patient feedback to achieve continuous improvement. While recognising that the Trust is operating in an increasingly challenging operating environment it is encouraging to note that the Trust continues to view with importance the collection and use of patients' views.

The Scrutiny Committee notes the levels of performance achieved during 2010/11 and supports the ambition of the organisation to exceed, rather than just meet, targets and to be in line with the best.

Karen Brown
Health Scrutiny Officer
17/05/2011

Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 2010-11;

- 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 2010 to June 2011

    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011

    - Feedback from the commissioners dated 20/05/2011

    - Feedback from the Health and Well-Being Scrutiny Committee dated 17/05/2011

    - Feedback from governors dated between 01/05/2011 - 20/05/2011

    - Feedback from LINks dated 20/05/2011

    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 04/05/2011

    - The national patient survey 21/04/2011

    - The national staff survey April 2011

    - CQC Quality Risk Profiles April 2011

    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 05/05/2011

- 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 that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

J N ANDERSON **Date: 2 June 2011**
Chairman

K W BREMNER **Date: 2 June 2011**
Chief Executive

Independent Auditor's Report to the Board of Governors of City Hospitals Sunderland NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of City Hospitals Sunderland NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the content of City Hospitals Sunderland NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with:

- Board minutes for the period April 2010 to June 2011
- Papers relating to quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 20/05/2011
- Feedback from governors dated 20/052011
- Feedback from LINKS dated 20/05/2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Compliance Regulations 2009, dated 20/042011;
- The national patient survey 2010;
- The national staff survey 2010;
- The Head of Internal Audit's annual opinion over the Trust's controls environment dated April 2011; and
- CQC quality and risk profiles dated April 2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of City Hospitals Sunderland NHS Foundation Trust as a body, to assist the Board of Governors in reporting City Hospitals Sunderland NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning

an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and City Hospitals Sunderland NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Making enquiries of management;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

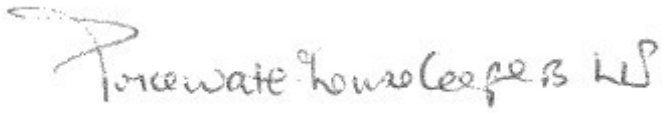
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual*.



PricewaterhouseCoopers LLP
Chartered Accountants
London