City Hospitals Sunderland NHS
NHS Foundation Trust

Quality Report 2011/12

Our annual report to the public about the quality of services we deliver

Quality Report

Contents Page

Overview

The Quality Report 2011/12 is an annual review of the quality of services provided by City Hospitals Sunderland NHS Foundation Trust during 2011/12. It is required by Government in an effort to strengthen and maintain the focus on quality of care for patients.

The Quality Report comprises three distinct sections.

- **Part 1** is a statement about what quality means to City Hospitals Sunderland, signed by the Chief Executive.

- **Part 2** highlights the trust's performance in 2011/12 compared to the priorities that were agreed and published in last year's report. Legislated statements of assurance from the Board of Directors complete this section.

- The key priorities for quality improvement in 2012/13 are highlighted in **Part 3**. Each priority is accompanied by specific indicators and initiatives, which have been chosen to address local and national quality challenges.

A draft version of the Quality Report 2011/12 was shared with our stakeholders in April 2012 as part of the assurance process. Each organisation was asked to review the draft report and provide a written statement for publication (unedited) in **Annex One**.

The Statement of Directors' Responsibilities in respect of the Quality Report is published as **Annex Two**.

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

About City Hospitals Sunderland NHS Foundation Trust

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

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

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

The Trust has 894 acute beds, an annual income of £306.02m and fixed assets of £205.37m. It employs 4940 people.

Part 1: Statement on Quality
from the Chief Executive

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

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

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

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

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

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

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

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

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

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

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

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

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

KEN BREMNER
Chief Executive **Date: June 2012**

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

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

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

Clinical Quality Priorities 2011/12 - Overview

Improvement Priority 1: Clinical Effectiveness

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

Improvement Priority 2: Patient Experience

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

Improvement Priority 3: Patient Safety

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

Improvement Priority 4: Patient Safety

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

Priority 1: Clinical Effectiveness

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

How did we do?

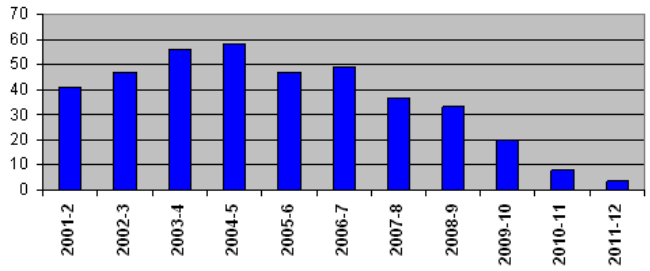
Indicator	07/08	08/09	09/10	10/11	11/12	Achieved / Not achieved
MRSA bacteraemia	37	33	20	8	4*	✓
Clostridium difficile	-	192	93	49	64	✘

* the cases represent all MRSA cases for comparison purposes (both hospital and community acquired)
Data source is the HPA Data Capture System and these are governed by standard national definitions

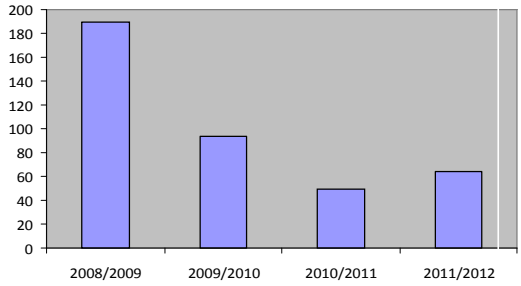
The yearly target for MRSA was 6 or fewer cases and the Trust has comfortably achieved the target with only **1 case reported** (and 3 community acquired infections). We remain one of the best performing Trusts in the region for prevention of MRSA infection. However during 2011/12 we reported higher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

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

MRSA bacteraemia 2001-2011



Hospital acquired C.*difficile* infection



Comments and progress

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

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

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

Other achievements during the year

- The Trust is compliant with the Health and Social Care Act 2008 (revised 2010),
- The Infection Prevention and Control Team participated in a national one week prevalence audit of MRSA admission screening,
- The review of Infection Prevention and Control mandatory training for all grades of staff,
- We have refreshed the hand hygiene audit programme to include the World Health

Organisation '5 moments for hand hygiene' campaign,

- We have devised an enhanced audit programme for environmental cleanliness, including medical devices and equipment,
- Mandatory reporting of Methicillin-sensitive *Staphylococcus aureus* (MSSA) and *E.coli* bacteraemia.

Key areas for further improvement

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

Priority 2: Patient Experience

To improve patient experience and overall satisfaction in key areas

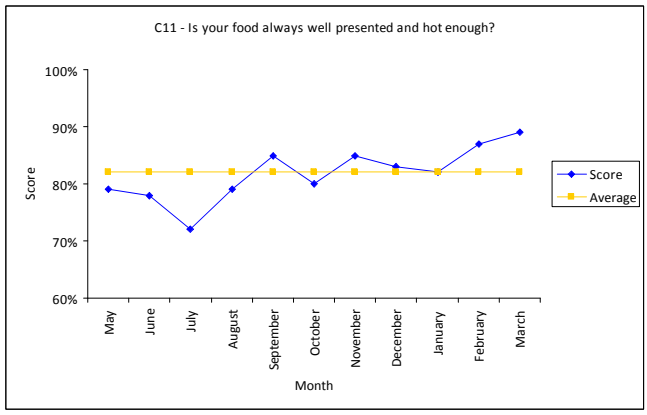
We are committed to improving the quality of patient experience and to do that, it is important that we listen to what patients and their families say about their treatment and care, in order to help us focus on where we need to improve. We said we would increase patient ratings around hospital food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

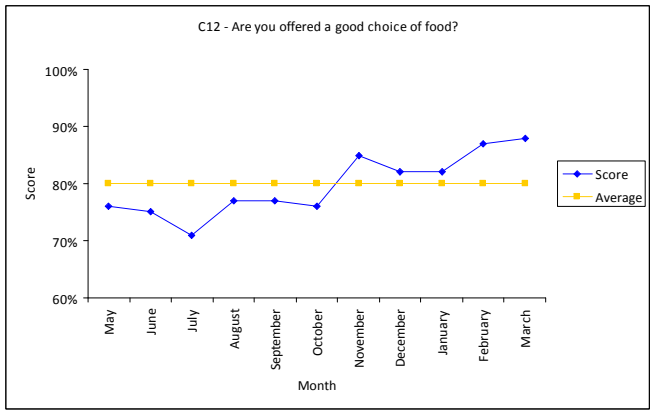
How did we do – hospital food?

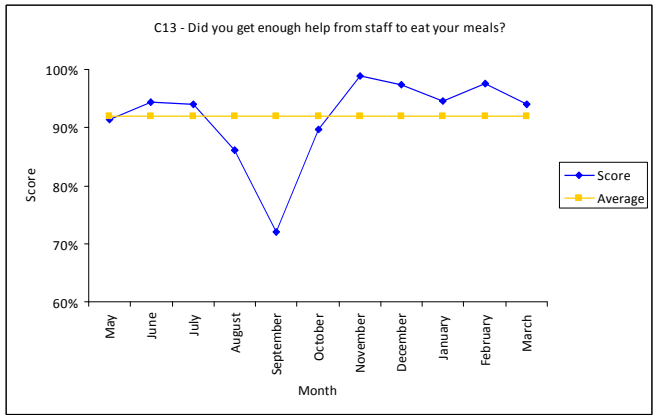
Indicator	07	08	09	10	11	Improvement
"Is your food always well presented and hot enough?"	N/A	N/A	N/A	N/A	N/A	N/A
"Are you offered a good choice of food?"	79	77	75	83	8.1~	✘
"Did you get enough help from staff to eat your meals?"	71	68	68	73	7.7	✓

Scores are for the annual national adult inpatient surveys (Picker Institute)
N/A – no equivalent question in the national adult inpatient survey
~ Survey report has changed; each Trust now receives a score out of 10 for each question

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







Comments and progress - hospital food

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

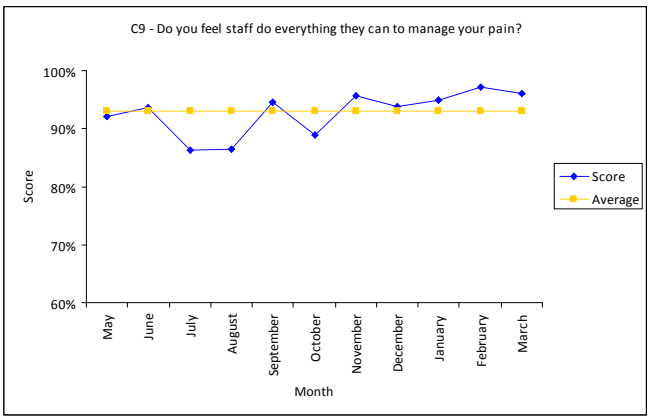
- Compliance with the Malnutrition Universal Screening Tool (MUST) is now more vigorously monitored by Ward Managers and Matrons,
- Introduction of visual prompts (knife & fork icons) at ward level for patients who require assistance,
- Introduction of the red tray system to promote patient assistance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

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

How did we do – patient's pain experience?

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

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



Comments and progress - pain management

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

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

Priority 3: Patient Safety

To improve the management of the deteriorating patient

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

How did we do?

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

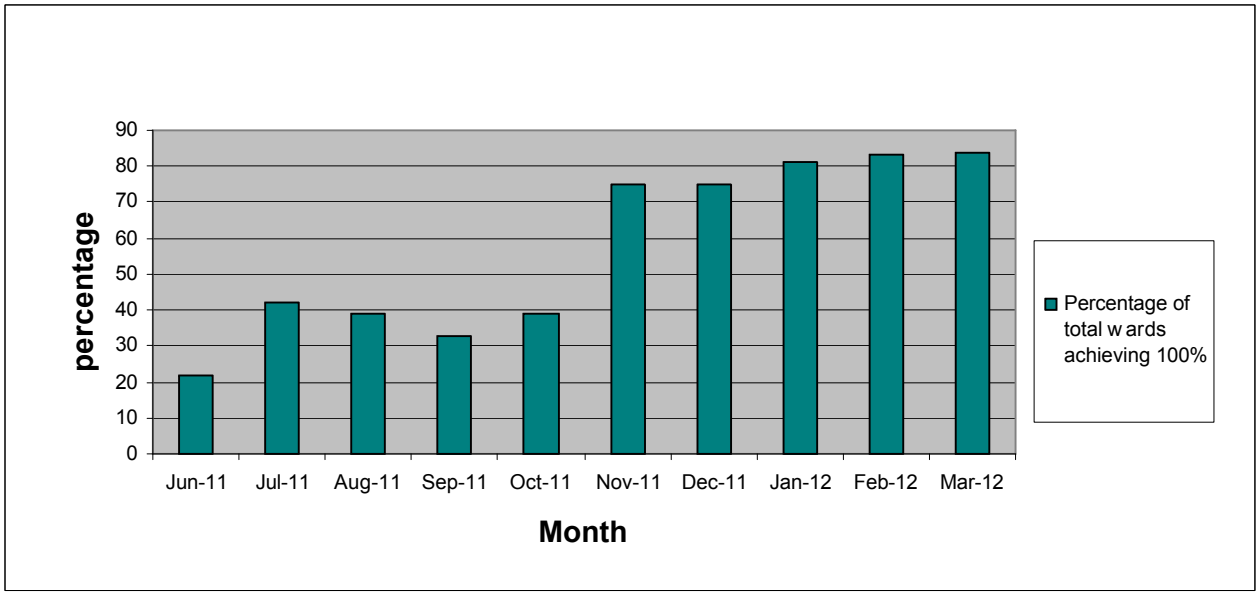
Data source - CHS Level of Care / Early Warning Score Point Prevalence Study
* nm – not measured because it was not part of the survey at the time

Comments and progress

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

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

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



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

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

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

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

Priority 4: Patient Safety

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

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

How did we do?

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

Source: City Hospitals' '*Safeguard*' system
* Incident impact moderate (3) and high (4) - a patient sustaining a moderate, major and catastrophic injury (using NPSA definitions)
** The figure has been readjusted (from 57) since 3 investigations were completed after the year

Comments and progress

- Numbers of falls – unfortunately we have unable to reduce the total number of reported falls (including slips and trips) this year and in fact we have had a small increase. The reasons why we did not reach our target will be thoroughly reviewed by the Trust Falls Group and action taken.
- We reduced by 35% the number of patient falls that had associated injury, this is a welcome and important outcome but we do recognise that more work is required and this is why reducing patient falls will continue to be one of our priorities next year,

- As part of our Commissioning for Quality and Innovation (CQUIN) scheme, the Trust has achieved and surpassed the quarterly targets set for the percentage of adult inpatients with a falls high risk score and documented action plan (*see Section 3 for further information*),
- We have introduced a Level 1 and 2 Falls teaching package for Health Care Assistants to help improve falls prevention, risk assessment and management practice in the wards ,
- We hold bi-monthly Falls awareness sessions to raise staff awareness and clarify the roles and responsibilities of link nurses,
- We have introduced a 'High Risk Fallers' stamp to identify those patients with a particular falls risk; this is also flagged on our HISS bulletin board (our electronic hospital information system).

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

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

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

Improvement Priority 1:
Clinical Effectiveness

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

Improvement Priority 2 :
Patient Experience

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

Improvement Priority 3:
Patient Safety

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

Improvement Priority 4:
Patient Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Indicators for quality improvement 2012/13

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

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

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

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

Statements of assurance from the Board

Review of services

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

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

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

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

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

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

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

The NHS Litigation Authority (NHSLA) conducts rigorous assessments of NHS organisations against a set of core Risk Management Standards. The standards and assessment processes are designed to provide a

structured framework to focus the organisation's risk management activities on delivering improvements in governance, patient care and the safety of patients, staff and visitors.

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

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

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

Accreditation schemes

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

- Joint Advisory Group (JAG) on Gastro-intestinal (GI) Endoscopy

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

These domains are monitored through a six monthly online self assessment process using a global rating score (GRS) that measures the quality of the service (in multiple areas). To maintain JAG accreditation the aim is to score "B" across the domains but with an "A" for timeliness. The domain scores are reviewed frequently (including the six monthly self assessment) to ensure appropriate scores to maintain accreditation. A portfolio of evidence is built up year by year to demonstrate good practice and is reviewed by JAG every five years during an inspection visit. The latest GRS report suggests that the Trust has further work to do in some key areas in order to renew its JAG accreditation in 2012.

- Clinical Pathology Accreditation (UK) Ltd

The Pathology laboratories, comprising Haematology and Blood Transfusion, Biochemistry, Histopathology and Cytology, and Microbiology have current accreditation with Clinical Pathology Accreditation (UK) Ltd (CPA). This is the internationally recognised body providing quality standards. Accreditation is reviewed bi-annually. The blood transfusion service also operates under the supervision

of the MHRA (Medicines and Healthcare products Regulatory Agency) and the Trust is compliant with the standards.

External assessment and visits

- Rheumatology

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

The report from the review summarises:

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

National Cancer Peer Review

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

Tumour site	Compliance	Type of assessment
Head & Neck MDT	76%	Formal Peer Review visit
Head &Neck Locality	78%	Formal Peer Review visit
Thyroid MDT	93%	Formal Peer Review visit
Teenage & Young Adults (TYA)	50%	Self assessment (SA) with external verification (EV)
Penile	75%	Self assessment (SA) with external verification (EV)
Gynaecology locality	80%	Self assessment (SA) with external verification (EV)
Chemotherapy services	85.4%	Self assessment (SA) with external verification (EV)
Oncology Pharmacy	100%	Self assessment (SA) with external verification (EV)
Intrathecal Chemotherapy	100%	Self assessment (SA) with external verification (EV)
Colorectal	89.7%	Self assessment (SA) with internal validation (IV)
Colorectal locality	100%	Self assessment (SA) with internal validation (IV)
Brain/Central Nervous System	100%	Self assessment (SA) with internal validation (IV)
Sarcoma Locality	100%	Self assessment (SA) with internal validation (IV)
Breast	80.6%	Self assessment (SA) with internal validation (IV)
Specialist Urology	90.7%	Self assessment (SA) with internal validation (IV)
Acute Oncology MDT	66.7%	Self assessment (SA) with internal validation (IV)
General Acute Oncology	54.6%	Self assessment (SA) with internal validation (IV)
Inpatient Acute Oncology	75%	Self assessment (SA) with internal validation (IV)
Lung	85.2%	Self assessment (SA) with internal validation (IV)
Upper Gastro Intestinal (UGI)	76.7%	Self assessment (SA) with internal validation (IV)

Action plans have been issued to each multidisciplinary team and meetings commenced to feed back compliance levels and requirements relating to improved documentation. For example, the Acute

Oncology Service is developing a neutropenic sepsis pathway for patients with low white cells who have an infection; implementing a patient alert database for emergency admission following chemotherapy and the service is working with specialists within the PCT to implement a new pathway for metastatic spinal cord compression.

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

- Head & Neck MDT & Head &Neck Locality
- Thyroid MDT (*Thyroid MDT at CHS is a sub-group of the specialist MDT at Newcastle, therefore formal visit and assessment was carried out at Newcastle General Hospital*)

Head & Neck MDT and Locality

The areas of good practice highlighted by the Peer Review assessors included:

- Achieved cancer wait targets,
- Cohesive cross-specialty team working,
- Speech & Language support,
- Mouth cancer awareness campaign,
- Robust palliative care attendance at MDT,
- Strong links with haematology and lung MDT's,
- Close collaboration between Sunderland and Newcastle histopathologists,
- No immediate risks identified.

Areas for improvement included:

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

These are being actioned through the relevant multidisciplinary group.

Thyroid MDT

A brief summary of the report (extracted from the Newcastle self assessment report) concludes:

- The MDT has had many innovations and achievements,
- Excellent performance against Cancer Waiting Time Standards,
- Strong patient centred focus with development of links to patient/carer groups,
- Commitment to maintaining strong clinical trials portfolio,
- No immediate risks,
- No serious concerns.

Participation in clinical audit and national confidential enquiries

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

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

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

National Clinical Audits

National Clinical Audits	Eligible	Participation	Compliance
Peri and neonatal care			
Perinatal mortality (CEMACH)	✓	✓	Continuous data collection*
Neonatal intensive and special care (NNAP)	✓	✓	Continuous data collection
Children			
Paediatric pneumonia (British Thoracic Society)**	✓	✘	No data submitted
Paediatric asthma (British Thoracic Society)	✓	✓	100% compliance. 24 cases submitted
Pain management (College of Emergency Medicine)	✓	✓	100% compliance. 50 cases submitted
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✓	✓	100% compliance. 30 cases submitted + user experience survey.
Paediatric intensive care (PICA Net)	N/A	N/A	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	N/A	N/A	N/A
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	Continuous data collection
Acute care			
Emergency use of oxygen (British Thoracic Society)	✓	✓	100% compliance. Organisational data and 40 cases submitted
Adult community acquired pneumonia (British Thoracic Society)***	✓	✘	No data submitted
Non invasive ventilation - adults (British Thoracic Society)***	✓	✘	No data submitted
Pleural procedures (British Thoracic Society)***	✓	✘	No data submitted
Cardiac arrest audit	✓	✓	Continuous data collection
Severe sepsis & septic shock (College of Emergency Medicine)**	✓	✘	No data submitted
Adult critical care (ICNARC CMPD)	✓	✓	Continuous data collection
Potential donor audit (NHS Blood & Transplant)	✓	✓	Undertaken by the Blood Centre, Newcastle
Seizure management (National Audit of Seizure Management)	✓	✓	100% compliance. Organisational data and 30 cases submitted
Long term conditions			
Diabetes (National Adult Diabetes Audit)	✓	✓	Continuous data collection.
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	✓	100% compliance
Chronic pain (National Pain Audit)	✓	✓	Continuous data collection

	Ulcerative colitis & Crohn's disease (UK IBD Audit)	✓	✓	100% compliance. Organisational data and 40 cases submitted.
	Parkinson's disease (National Parkinson's Audit)	✓	✓	100% compliance. 20 cases submitted.
	Adult asthma (British Thoracic Society)	✓	✓	100% compliance. Organisational data and 11 cases submitted
	Bronchiectasis (British Thoracic Society)	✓	✓	100% compliance 13 cases submitted
Elective procedures				
	Hip, knee and ankle replacements (National Joint Registry)	✓	✓	Continuous data collection
	Elective surgery (National PROMs)	✓	✓	Continuous data collection
	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
	Liver transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
	Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	✓	Continuous data collection
	Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✓	✓	Continuous data collection
	Carotid interventions (Carotid Intervention Audit)	✓	✓	Continuous data collection
	CABG and valvular surgery (Adult cardiac surgery audit)	N/A	N/A	N/A
Cardiovascular disease				
	Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	Continuous data collection
	Heart failure (Heart Failure Audit)	✓	✓	Continuous data collection
	Acute stroke (SINAP)	✓	✓	Continuous data collection
	Cardiac arrhythmia (Cardiac Rhythm Management Audit)	✓	✓	Continuous data collection
Renal disease				
	Renal replacement therapy (Renal Registry)	✓	✓	Continuous data collection
	Renal transplantation (NHSBT UK Transplant Registry)	N/A	N/A	N/A
Cancer				
	Lung cancer (National Lung Cancer Audit)	✓	✓	Continuous data collection
	Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	Continuous data collection
	Head & neck cancer (DAHNO)	✓	✓	Continuous data collection
	Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	Continuous data collection
Trauma				
	Hip fracture (National Hip Fracture Database)	✓	✓	Continuous data collection
	Severe trauma (Trauma Audit & Research Network)	✓	✓	Continuous data collection
Psychological conditions				
	Prescribing in mental health services (POMH)	N/A	N/A	N/A
	Schizophrenia (National Schizophrenia Audit)	N/A	N/A	N/A

Blood transfusion				
	Bedside transfusion (Comparative Audit of Blood Transfusion)	✓	✓	Partial compliance - only submitted 21 cases (recommended 70)- 30%~
	Medical use of blood (Comparative Audit of Blood Transfusion)	✓	✓	100% compliance – submitted 90 cases
Health promotion				
	Risk factors (National Health Promotion in Hospitals Audit)	✓	✘	Did not participate
End of life				
	Care of dying in hospital (NCDAH)	✓	✓	100% compliance. Organisational data and 50 cases submitted.

* Yes the trust is participating in the audit; data is collected on a continual basis rather than a sample of patients.
** Not able to participate this year because of limited time and resources.
*** Not able to undertake all BTS audits but managed to participate in more audits than 2010/11.
~ partial compliance, pressure on internal staff resource meant that study sample was not achieved.

National Confidential Enquiries 2011/12

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

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

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

* This was a prospective study and, this is the total number from which a sample of 7 cases only were required to be reviewed
** No children fulfilled the study criteria during the time frame

Summary of national clinical audits

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

National Audit of Dementia (Care in General Hospitals)

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

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

UK Inflammatory Bowel Disease (IBD) Organisational Audit

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

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

National Kidney Care Audit (Vascular Access)

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

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

National Lung Cancer Audit (LUCADA)

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

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

National Audit of Diabetes Inpatients

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

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

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

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

Local clinical audit

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

- The development of an information pack for patients attending the low clearance clinic in Renal (for those with impaired kidney function) to help them make an informed decision about their future treatment,
- Haematology and Microbiology are working together to refine the use of Procalcitonin assay (special blood test) in a selected population of patients who are febrile and undergoing treatment for malignancies,

- The introduction of a standardised neutropenic sepsis pathway (fever in patients with low white blood cells) with accompanying clear and concise documentation,
- The development and implementation of patient group directions for the management of chemotherapy toxicities and neutropenic sepsis (these allow certain health professionals to supply and administer specified medicines to particular patients),
- Following an audit which looked at the current management pathway of patients with malignant otitis externa (inflammation of the outer ear and ear canal), we have introduced a new pathway of care. This should help reduce patients' length of stay significantly and also reduce the number of cannulas patients have inserted, which in turn may reduce the risk of infection and line-related complications,
- Continuous audit of intravenous fluid use in the Integrated Critical Care Unit (ICCU) has led to a reduction in colloid (special fluids) use with a cumulative saving of £89,000 and no associated adverse events.
- The Emergency Department has shown a reduction in the number of attendances of the most frequent service users following the appointment of a care navigator to facilitate assertive outreach by the hospital alcohol team. Weekly multidisciplinary meetings involving social services, community alcohol teams and voluntary sector organisations are held to review attendance patterns and help identify and provide appropriate support to these individuals,
- To improve discharge planning for children with asthma, the paediatric wards have created an asthma checklist which is completed on discharge and is based upon national 'best practice' standards for managing acute wheezing and asthma.

Participation in clinical research

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

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

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

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

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

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

Information on the use of the CQUIN framework

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

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

In 2010/11 the income attached to delivery of quality improvements through CQUIN was £3.5m.

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

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

No	Description of Goal	Indicator	Priority	Weighting	Achievement of target
1	Reducing harm from Venous Thromboembolism (VTE)			10	
1a		% of all adult inpatients who have had VTE risk assessment on admission to hospital, using the clinical criteria of the national tool	National	3	
1b		Proportion of patients assessed to be at increased risk of VTE who are offered VTE prophylaxis in accordance with NICE guidance		3	
1c		Proportion of patients/carers who are offered verbal and written information on VTE prevention as part of the admission process (NICE VTE quality standards)		1	
1d		i) Proportion of all adult inpatients discharged then readmitted within 90 days for pulmonary embolism (PE)		0	
		ii) Identification of patients readmitted with PE and completion of root cause analysis to identify learning and implement appropriate improvements		3	
2	Improving patient experience			10	
2a		Composite measure "Improving responsiveness to personal needs of patients" from the adult inpatient survey (Goal 70)	National	2	
2b		Identified areas for improvement not covered by the adult inpatient survey – paediatrics	Local	4	
2c		Implementation of action plan following inpatient or outpatient survey results CHS - food		4	
3	Effective management of long term conditions (LTC) to improve patient outcomes and minimise readmissions			20	
3a		Proportion of eligible stroke patients that receive all nine indicators from the bundle of care, as defined in the sentinel stroke audit	Local	8	
3bi		% of patients receiving all 4 indicators from the heart failure bundle (set of interventions that, when used together, significantly improve patient outcomes)		3	
3bii		% of patients receiving all 7 indicators from the heart failure bundle		1	
3c		COPD - Joint discharge planning with community teams to reduce repeat emergency attendances.		8	
4	Reduction in harm from pressure ulcers			10	
4a		Reduce number of grade 2 and above hospital acquired pressure ulcers (rate by bed days)	Local	5	
4b		Reduce number of pressure ulcers that deteriorate		5	

5	Reduce harm from falls			10	
5a		% of adult inpatients with falls high risk score that have a documented action plan	Local	3	
5b		Review current arrangements (including data collection/coding) for care provided to patients attending A&E following a fall and develop and implement an improvement plan		7	
6	To support mothers to initiate and continue breastfeeding			5	
6a		Proportion of women that initiate breastfeeding following birth	Local	2	
6b		Proportion of women who initiate breastfeeding following birth and continue until discharge from midwifery care		3	
7	To use preassessment as a health improvement opportunity with patients that smoke			5	
7a		Proportion of patients who have attended preassessment appointment with smoking status recorded		2	
7b		Proportion of patients who have attended preassessment appointment recorded as smokers who have received a brief intervention		3	
8	To improve the standard of end of life care for patients in an acute setting			10	
8a		Number of patients on the Liverpool Care Pathway as a proportion of those expected to die	Local	2	
8b		Implementation of an improvement plan in one specialty that includes	Local	8	
		Proportion of staff competent in using the Advance Care Plan			
		Percentage of eligible patients offered an Advance Care Plan discussion			
		Percentage of eligible patients where offer of Advance Care Plan has been reviewed			
		Completion of Advanced Care Plan documentation			
9	To improve productivity, clinical effectiveness and patient experience through pathway reform			15	
9a		Introduction one stop care in one cancer service (breast)	Local	7.5	
9b		Planned care - Implementation of the enhanced recovery model of care, in one area to reduce length of stay (colorectal)		7.5	
10	To improve experience of patients with learning disabilities			5	
10a		Improvement in the coding and flagging systems for people with learning disabilities and implementation of regional learning disability care pathways		5	

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**.

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

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

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

Care Quality Commission – Review of Compliance (December 2011)

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

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

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

CareQuality Commission

Review of compliance

City Hospitals Sunderland NHS Foundation Trust Sunderland Royal Hospital	
Region:	North East
Location address:	Sunderland Royal Hospital Kayll Road Sunderland Tyne and Wear SR4 7TP
Type of service:	Acute services with overnight beds Rehabilitation services Diagnostic and/or screening service
Date of Publication:	December 2011
Overview of the service:	City Hospitals Sunderland provides acute hospital services to the Sunderland area as well as some specialist services for the wider geographical area. This includes acute services for elective and emergency care including in-patient, outpatient, and

What we found for each essential standard of quality and safety we reviewed

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

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

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

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

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

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

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

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

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

"Overall, we found that Sunderland Royal Hospital was meeting this essential standard. The quality of the service offered was regularly monitored and processes were in place that identified, assessed and managed risks relating to the health, welfare and safety of patients and staff."

OFSTED/Care Quality Commission visit

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

Information on the quality of data

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

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

The percentage of records in the published data which included the patient's valid NHS number was:

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

The percentage of records in the published data which included the 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 2012. City Hospitals Sunderland Information Governance Assessment Report overall score for 2011/12 was 83% and was graded green (satisfactory).

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

Accident and Emergency

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

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

The Trust's Data Quality department are working with the A&E team to improve the recording of key data to improve the accuracy of the indicators outlined above.

Small Systems

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

Clinical coding error rate

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

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

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

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

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

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

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

* Updated version of RAMI (RAMI 2012) – each year the rate is re-based

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

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

[1] Hospital acquired

[2] Community acquired

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

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

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

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

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

Description of Goal	09/10	10/11	11/12
4. Preventing occurrence of any 'Never Events'*	Not Available	Not Available	4

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

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

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

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

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

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

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

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

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

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

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

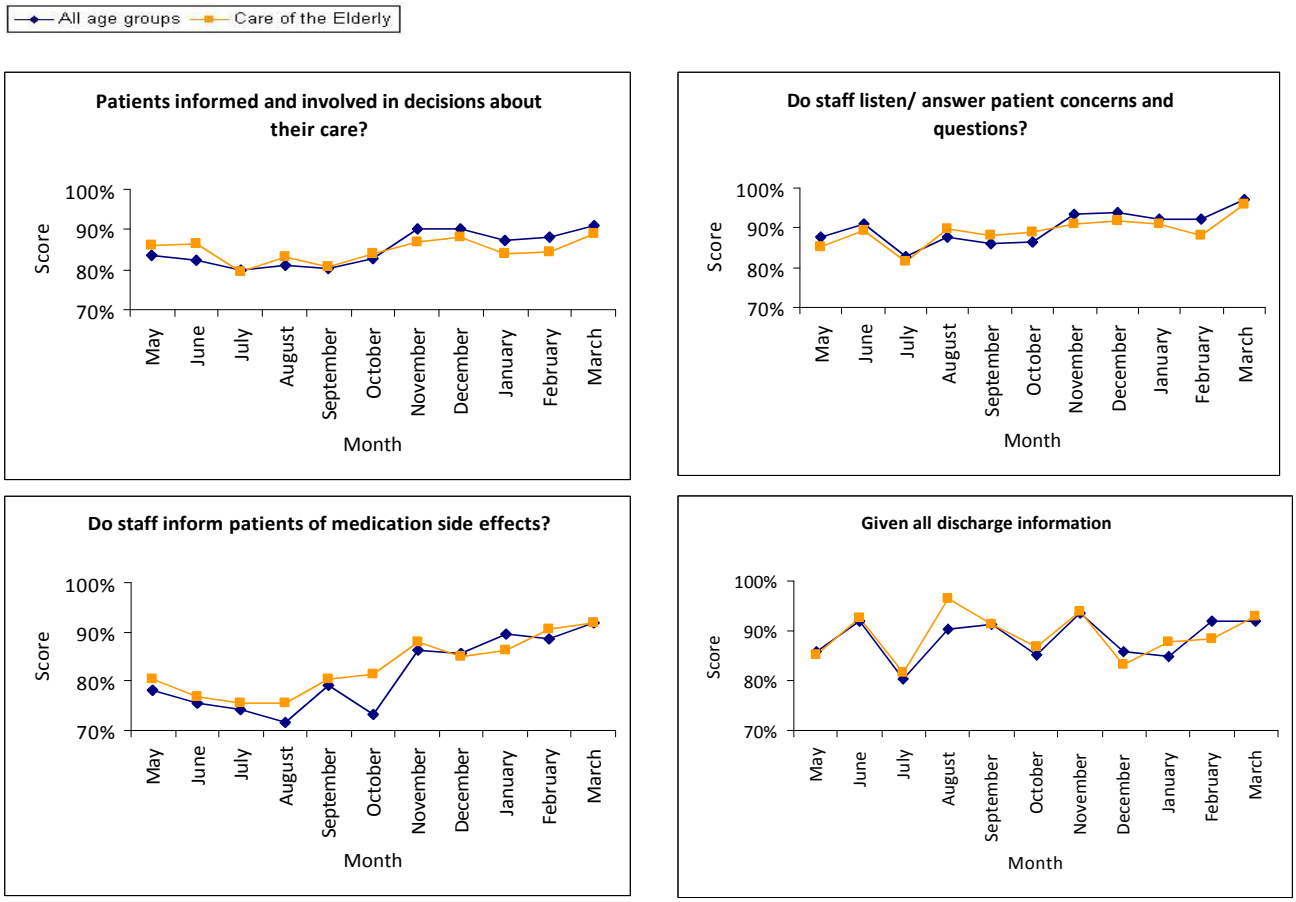
c) Patient Experience						
Metric	Description of Goal	07	08	09	10	11~
Eliminate mixed sex accommodation	Minimising use of same bathroom or shower area for patients of the opposite sex	74	78	79	75	8.7
Communication indicators	Patients involved as much as they wanted to be in decisions about care	71	73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

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

Comments on the patient experience measures

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

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

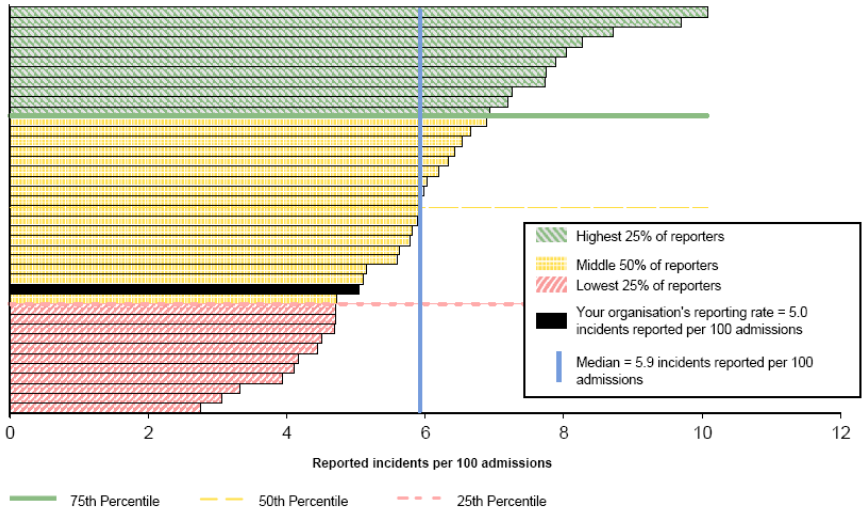


Additional information about our quality improvements

Focusing on Patient Safety

i) Reported patient safety incidents

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



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

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

	Severe harm	Death
1 April 2011 to 30 September 2011	33	8
1 October 2010 to 31 March 2011	57	10
1 April 2010 to 30 September 2010	47	8

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

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

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

iii) High Impact Safety Messages

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

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

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

Focusing on Clinical Effectiveness

i) Venous Thromboembolism (VTE)

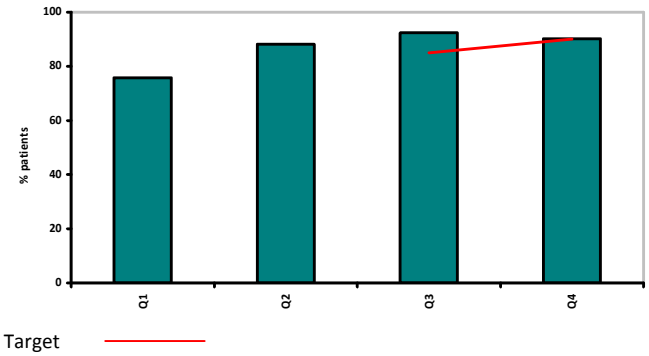
Venous Thromboembolism (VTE) or formation of a blood clot is a condition that can cause a significant number of deaths each year, many of which could be avoided. In 2010 a number of measures were introduced across the NHS to help ensure that every adult patient had a documented VTE risk assessment on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

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

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

% of all adult inpatients who have had VTE risk assessment on admission to hospital

% of patients at risk of VTE who are offered VTE prophylaxis



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

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

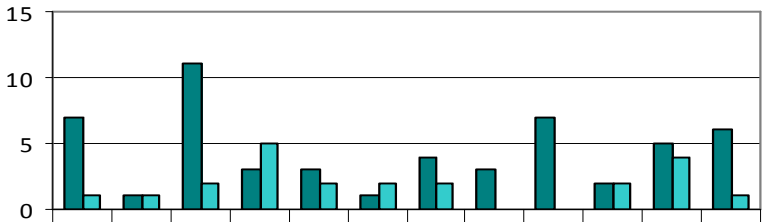
Pressure ulcers represent a major burden of ill health and reduced quality of life for patients, their carers and families. During 2011/12 the Trust has continued to prioritise this area of clinical practice and we had two related targets in our CQUIN scheme; to reduce both the number of Grade 2 and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

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

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

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

Number of Pressure Ulcers Grade 3 and 4 >72 hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Grade 3	7	1	11	3	3	1	4	3	7	2	5	6
Grade 4	1	1	2	5	2	2	2			2	4	1

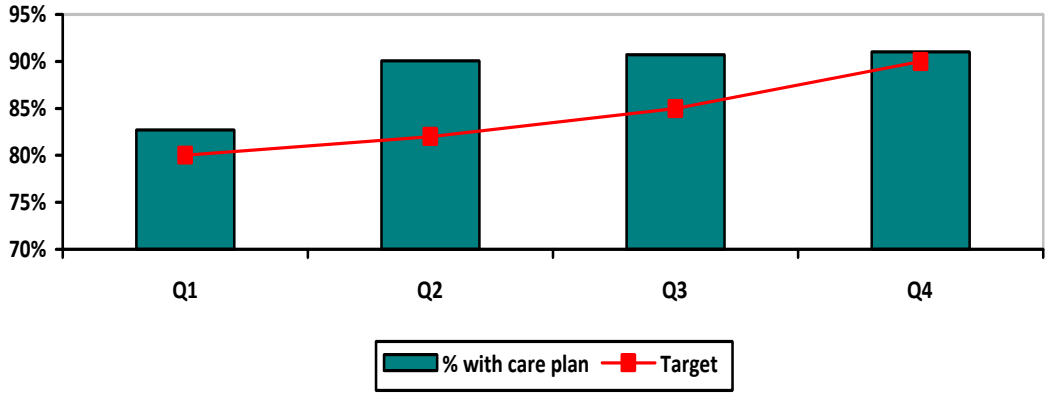
Highest Grade	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
3	7	1	11	3	3	1	4	3	7	2	5	6	53
4	1	1	2	5	2	2	2			2	4	1	22
Grand Total	8	2	13	8	5	3	6	3	7	4	9	7	75

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

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

iii) Falls prevention and management

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



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

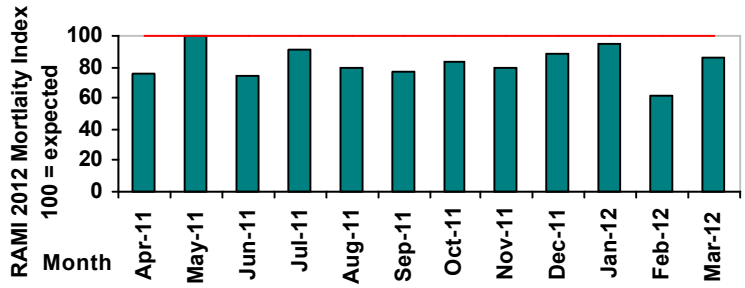
- Measuring and monitoring of the CQUIN target, ' % over 65's attending A&E with fall/blackout or fracture resulting from a fall',
- Revising and updating the 'Prevention and Management of Hospital Based Patient Falls Policy' in line with best practice,

- Consolidation of the Falls link-staff sessions that are held bi-monthly and which provide an essential information exchange within the hospital.

iv) Mortality

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

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



(Governed by CHKS definitions)

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

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

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

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

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

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

Indicator	April 10-March11	June 10-June 11
SHMI value	1.0693	1.0166
SHMI banding	Band 2 - **'as expected'**	Band 2 - **'as expected'**
% of patients admitted to the Trust whose treatment included palliative care	0.7	0.8*
% of patients admitted to the Trust whose deaths were included in SHMI and whose treatment included palliative care	11.1	12.5**

* National average is 0.9%
** National average is 16%

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

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

Focusing on Patient Experience

i) The NHS Adult Inpatient Survey 2011

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

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

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

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

From the more detailed results, the survey shows that across the 64 questions which measure our performance from the patients perspective, 63 (98.5%) are in the amber 'expected range' category meaning that we are about the same as most other Trusts in the survey. 1 question is in the green category meaning that we scored 'better' than the majority of trusts. We have no questions in the red or 'worst' category.

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

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

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

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

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

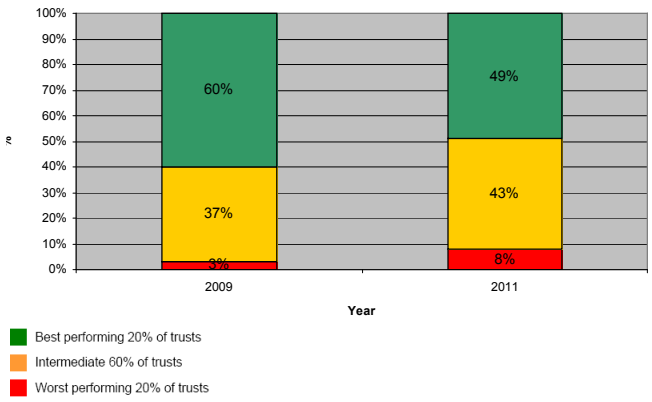
ii) The NHS Outpatient Department Survey 2011

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

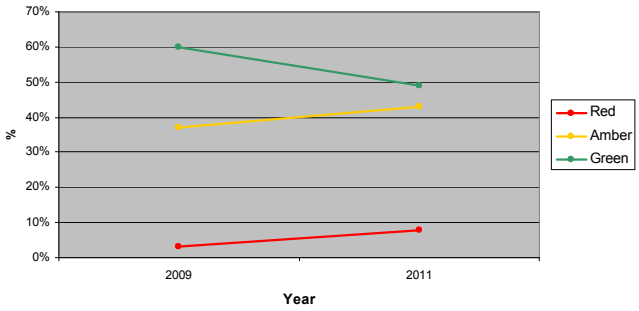
The Outpatient Department survey results are collated nationally and contribute to the Care Quality Commission's assessment of Trust performance against the essential standards of quality and safety.

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

Distribution of category ratings for surveys 2009 & 2011



Trends of category ratings for surveys 2009 & 2011



Did we do any better than last time?

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

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

We know where we need to improve

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

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

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

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

What did our patients say?

Positive comments

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

Negative comments

- *Time keeping for appointment time. Crowded waiting room. No seats available at first.*
- *Parking. I have been to the hospital on numerous occassions and only been able to park in the grounds once. Usually have to park up to a quarter mile away or more.*
- *It would be helpful if the appointment letter stated that you would need an x-ray when you arrived.*
- *Better directions to departments.*

- *Stop changes to appointment dates, a patient get his/her hopes built up that something is at last going to be done to alleviate their condition, but a week before the date their hopes are dashed because of yet another change to their appointment time.*

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

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

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

Experience was less positive around parental involvement and discussions about their baby's condition or care. Lack of privacy and space within the neonatal unit also contributed to a number of red scores*.
* the Neonatal Unit is undergoing refurbishment in 2012

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

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

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

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

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

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

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

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

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

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

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

Being responsive to the personal needs of patients

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

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

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

Staff views on the standards of care

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

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

Source – NHS Staff Survey 2011
* Percentage calculated by adding together the staff who agree and the staff who strongly agree with this statement

iv) Real Time Feedback

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

Real Time Feedback started in August 2010 and since then the Trust has received and analysed 4653 patient questionnaires, many of which include additional patient comments.

Where are we doing well?

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

* Each 'model' is equivalent to a score of 10

What do patients want us to improve?

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

* Each 'model' is equivalent to a score of 10

What improvements have we made?

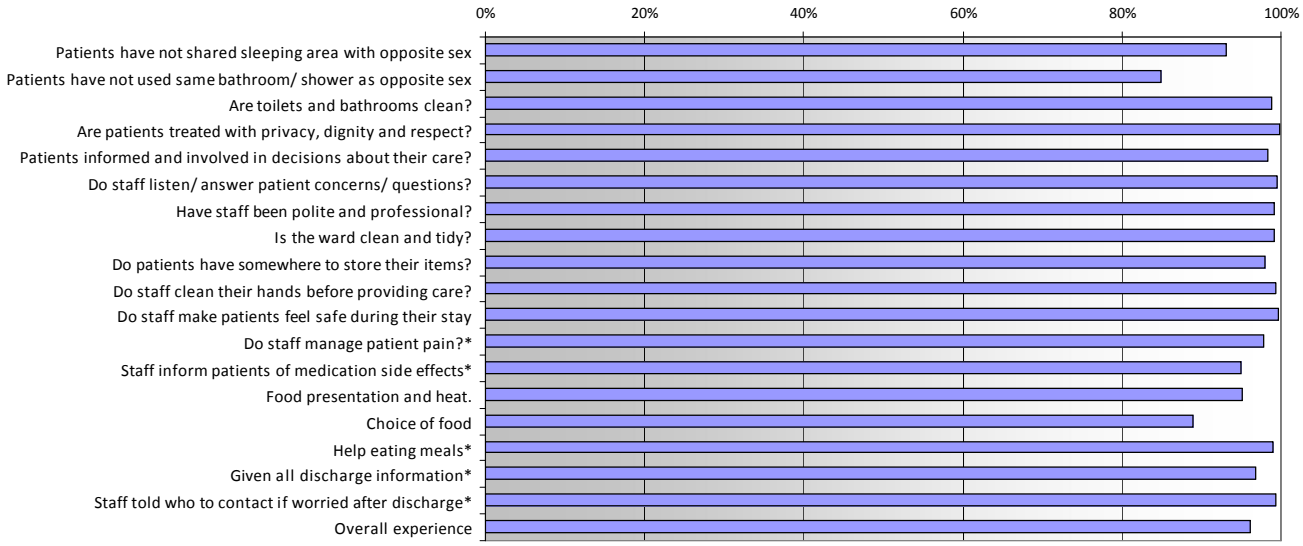
Simply collecting feedback from patients by itself has no value. It needs to be used by clinical and management staff to identify aspects of their service that need to improve, so that the team can take appropriate action. The following examples highlight where staff and teams have acted on the findings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

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

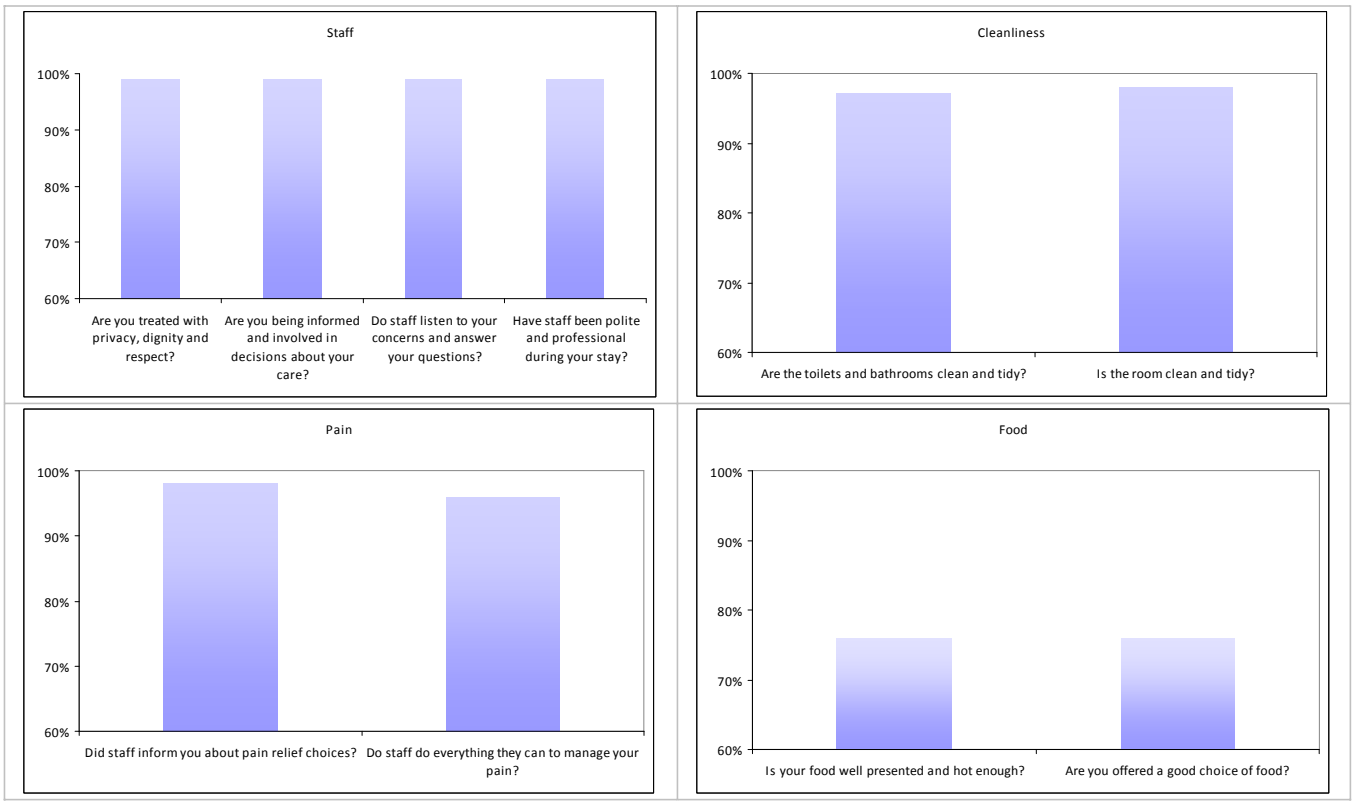
What we said we would do to make improvements to real time feedback

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

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



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

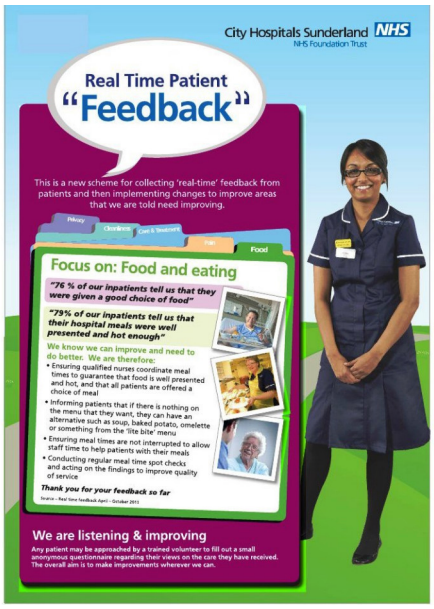


A number of areas to focus on in Maternity include; the offer of home births, partner stays and food options.

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

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

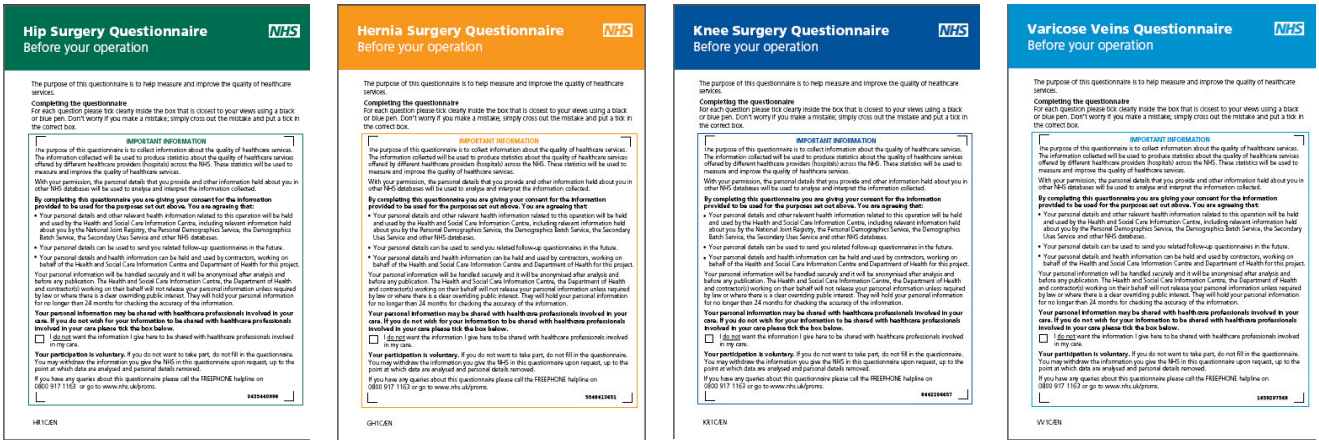
The poster below shows our first real time feedback poster highlighting to patients and their visitors the improvements we have made to hospital meals; these were widely circulated to all wards and departments and made available in reception and public areas. The next poster will show improvements in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



v) Patient Reported Outcome Measures (PROMS)

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

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



Information : Quality Health

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

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

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

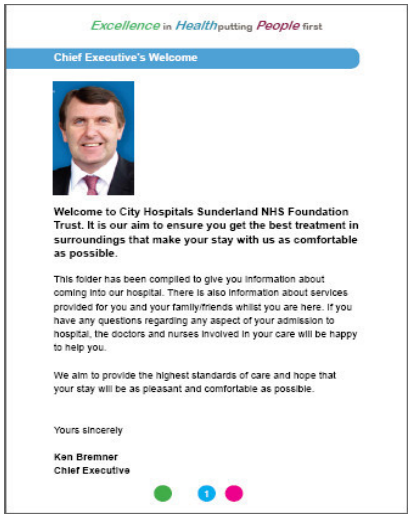
Source – Acute Trust Quality Dashboard (East Midlands Quality Observatory)
* City Hospitals position is noted by the blue diamond ◆

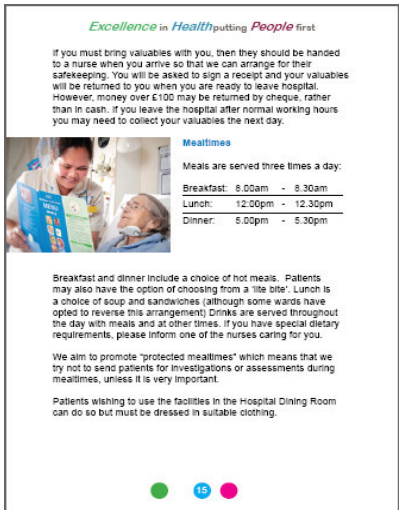
During the period April – Sep 2011, patients reported improvements, in terms of health gain, i.e. levels of mobility, self-care, pain and discomfort and anxiety, in three out of the four procedures; with only hernia surgery very slightly below the national average. The largest health gain can be found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

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

vi) Your Stay in Hospital Bedside Folder

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





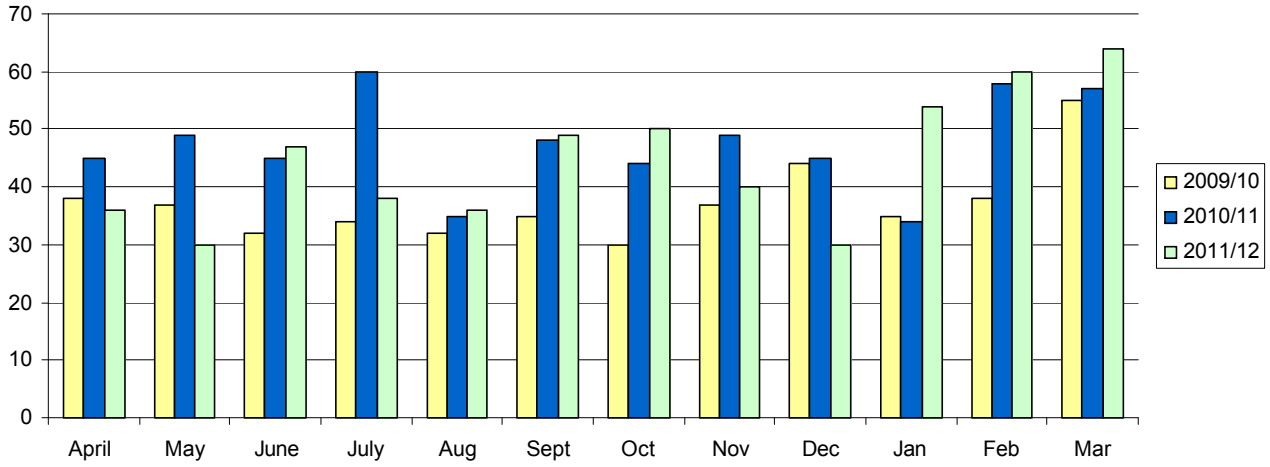
Our Community Panel will be undertaking an evaluation of their accessibility and value to patients and visitors during the Spring 2012. In addition we are also negotiating a contract to review and professionally print our range of bereavement booklets during 2012.

vii) Listening to patients – learning from our complaints

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

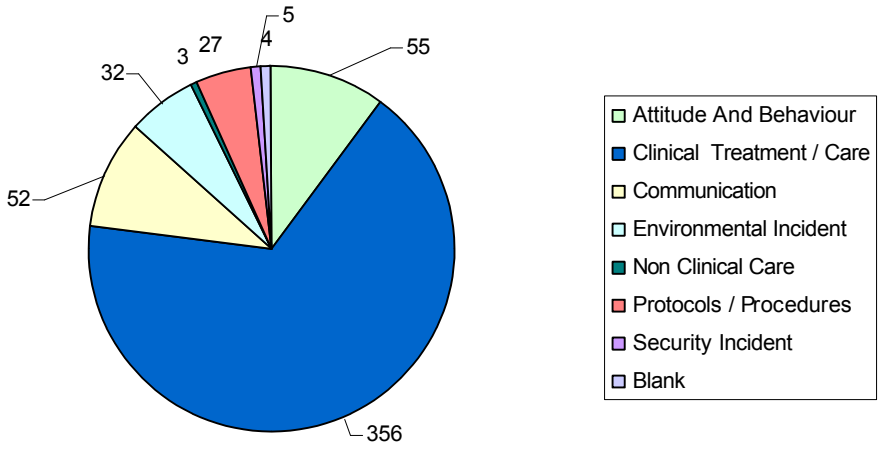
During 2011/12 the Trust received 534 formal complaints from patients or their representatives. This represents a 6% decrease compared to last year. The chart below shows the distribution of complaints received each month for the current and previous two years.

Comparison of complaints activity 2009/10 to 2011/12



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

Complaints activity by corporate theme 2011/12



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

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

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

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

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

viii) Community Panel

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

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

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

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

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

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

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

* (this was identified in error as Excellent in last year's Annual Report)

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

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

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

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

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

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

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

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

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

xi) Making improvements to our services

Improving quality using *Lean* tools and techniques

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

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

Patient Contact Centre

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

Emergency Care Pathway

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

The Productive Operating Theatre (TPOT)

Building on the Time to Care Programme, TPOT has been introduced to operating theatres. The aim of TPOT is to deliver the perfect operating list through visual management systems, process improvement and standardisation across the theatre complex. This project has supported theatre teams to reorganise and redesign the way they manage and do their work so there is now; i) an improved working environment,
ii) better management of equipment and stock, iii) turn around time has been reduced to enable operations to run more smoothly and iv) a reduction in the number of cancelled operations.

Enhanced Recovery Pathway

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

Radiology reporting

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

Bed Management and Discharge

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

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

Urology: Prostate Cancer Pathway

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

New Integrated Critical Care Unit

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

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

Reflecting the priority of the highest standards of infection control and a clean patient environment, specially designed dirty water disposal sinks have been developed by the Trust's Microbiology Department. Each room in the department also includes unique clinical waste bins on the back walls, also specially designed by staff, which enable material to be emptied directly from the ICCU rooms to the external corridor, thus reducing the risk of infection to patients.

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

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

Outpatient Reminder Service Pilot

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

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

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

Community Stroke Rehabilitation Team Win National Award

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

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

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

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

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

Performance against key national priorities

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

The table below highlights the Trust's performance against key national priorities in accordance with the NHS Operating Framework 2011/12. Many of these indicators are also used as part of Monitor's compliance framework, along with financial information, as the primary basis for assessing the compliance risk of NHS Foundation Trusts with their terms of Authorisation.

Indicator	Last Year 2010/11	Target 2011/12	YTD 2011/12	YTD Variance	YTD
Quality (Safety, Effectiveness & Patient Safety)					
HCAI measure (MRSA)[1]	3	<6	1	-5	●
HCAI measure (CDI)[1]	49	<44	64	20	●
Patient Experience Survey	68.3	N/A	71.4	N/A	●
Referral to Treatment waits (95th percentile) admitted patients[2,3]	N/A	23 weeks	17.72	-5.28	●
Referral to Treatment waits (95th percentile) non-admitted patients[2,3]	N/A	18.3 weeks	13.74	-4.56	●
Referral to Treatment waits (95th percentile) incomplete pathways[2,3]	N/A	28 weeks	19.43	-8.57	●
MSSA Breaches[2]	N/A	N/A	3	N/A	●
A&E - Unplanned Re-attendance Rate[2]	N/A	5%	2.95%	-2.05%	●
A&E - Total Time in the A&E Department	95.64%	95%	95.49%	0.49%	●
A&E - Left Without Being Seen Rate[2]	N/A	5%	1.94%	-3.06%	●
A&E - Time to Initial Assessment[2]	N/A	15 minutes	62	47	●
A&E - Time to Treatment[2]	N/A	60 minutes	43	-17	●
All Cancer Two Week Wait	93.39%	93%	94.12%	1.12%	●
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	96.74%	93%	96.14%	3.14%	●
All Cancer 62 day urgent referral to treatment wait	86.49%	85%	89.08%	4.08%	●
62 day wait for first treatment following referral from an NHS Cancer Screening Service	95.24%	90%	95.83%	5.83%	●
31 day standard for cancer diagnosis to first definitive treatment	98.05%	96%	99.31%	3.31%	●
31 day standard for subsequent cancer treatments - surgery	98.10%	94%	99.28%	5.28%	●

31 day standard for subsequent cancer treatments - anti cancer drug regimens	100.00%	98%	100.00%	2.00%	●
Emergency Readmissions[4]	6.33%	<10/11	6.70%	0.37%	●
VTE risk assessment for inpatient admissions	59.46%[5]	90%	92.13%	2.13%	●
Quality stroke care - people who have a stroke who spend at least 90% of their time in hospital on a stroke unit	81.46%[6]	80%	85.05%	5.05%	●
Quality stroke care - people at high risk of stroke who experience a TIA are assessed and treated within 24 hours	N/A	60%	60.85%	0.85%	●
Maternity 12 weeks[7]	82.62%	90%	87.30%	-2.70%	●

[1] Cases apportioned to Acute Trust

[2] New indicator from the Operating Framework for 2011/12

[3] Latest monthly position

[4] CHKS sourced. 2011/12 position does not include March

[5] New indicator from the Operating Framework for 2010/11 (measured from June 2010)

[6] Quarter 4 2010/11

[7] Quarter 2 assessments divided by quarter 4 deliveries

Healthcare Associated Infection

The Trust achieved the national target for MRSA in 2011/12, however, the Trust failed to achieve the target for *C. difficile* infections. Due to the significant progress made by the Trust in 2010/11 to reduce the number of *C. difficile* infections, the target itself was more than halved from less than 98 cases in 2010/11 to less than 44 in 2011/12. This target has proved to be extremely challenging, despite a continued focus and commitment on reducing healthcare associated infections. We continue to look at ways to minimise the risk of patients developing these infections going forward into 2012/13. Further information on both these targets can be found within Part 2 of the Quality Report.

Referral to Treatment Waits

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

Accident & Emergency (A&E)

During 2011/12 the Trust experienced significant operational pressures over the winter period with increased A&E attendances, and, on one occasion 447 patients attended the emergency department on a single day. There has also been an increase in the number of patients admitted to hospital from A&E

and during the winter period a high proportion of patients with complex clinical conditions has required them to stay in hospital longer. Despite these pressures, the whole organisation has contributed towards delivery of the A&E target of 95% of patients spending less than 4 hours in the department. During 2012/13 we will continue to work with partner organisations such as GP practices, North East Ambulance Service, Community and Social Services to ensure Sunderland has a cohesive service for patients with urgent and emergency needs.

Cancer

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

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

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

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

Venous-thromboembolism (VTE) Risk Assessments

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

Stroke

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

Maternity 12 weeks

The Trust continues to provide high standards of early access for women to maternity services, but due to difficulties in recording the first time women see a midwife or maternity healthcare professional, performance has not been truly reflective of these high standards. During 2011/12 the Trust changed the process of capturing this data in order to address the issue, and this has resulted in a significant increase in performance from 82.3% in 2010/11 to 87.3% in 2011/12. Since performance is measured at the point of delivery, almost nine months later, the benefits of the new process have not yet been fully realised and as a result the Trust was slightly below the 90% target. Nevertheless, performance is improving and the Trust is expected to achieve the target in 2012/13.

Annex One

Statement from Lead Commissioner: Sunderland Teaching Primary Care Trust

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

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

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

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

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

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

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

It is positive that the priorities for 2012/13 have been identified with Governors and LINks and whilst they focus on strengthening the basics of healthcare there are also

other improvement priorities for instance those with the 2012/13 CQUIN scheme particularly dementia care and reduction in harm from pressure ulcers.

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

Date: 28 May 2012

Statement from Sunderland Local Involvement Network (LINk)

Sunderland LINk has pleasure in contributing to the above, as part of CHS's Quality Report and we accept that certain data at the time of reading are incomplete.

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

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

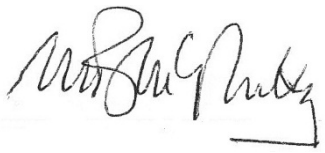
Certain findings proved worrying, such as the few cases where a patient was left unaccompanied when bad news had to be imparted, patient concerns on poor staff communication to them, (but this is not always easy to measure), pain management aspects, (although this is already fully acknowledged as an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

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

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

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

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



Mike McNulty
Chair Sunderland LINk **Date: 24 May 2012**

Statement from Overview and Scrutiny Committee (OSC)

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

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

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

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

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

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

Karen Brown
Health Scrutiny Officer **Date: 23 May 2012**

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

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

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;

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

  - Board minutes and papers for the period April 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 28 May 2012
  - Feedback from governors dated 12 April 2012
  - Feedback from LINks dated 24 May 2012
  - Feedback from Overview and Scrutiny Committee dated 23 May 2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11 May 2012
  - The national patient survey 24 April 2012
  - The national staff survey 26 April 2012
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 April 2012
  - CQC quality and risk profiles dated April 2012

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

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

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

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

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

By order of the Board

J N ANDERSON
Chairman **Date: 29 May 2012**

K W BREMNER
Chief Executive **Date: 29 May 2012**

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

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

Scope and subject matter

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

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

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

Respective responsibilities of the Directors and auditors

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

MRSA bacteraemia

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

All cancer 62 day urgent referral to treatment wait

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

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

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

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

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

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

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

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of City Hospitals Sunderland NHS Foundation Trust as a body, to assist the Board of Governors in reporting City Hospitals Sunderland NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and City Hospitals Sunderland NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

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

Conclusion

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

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

PricewaterhouseCoopers LLP
Chartered Accountants
Newcastle upon Tyne
30 May 2012

The maintenance and integrity of the City Hospitals Sunderland NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

How you can provide feedback on our Quality Report

Production of the Quality Report

We are very grateful to all those who have contributed to the production of this year's Quality Report 2011/12. The Trust welcomes any comments you have about the current Quality Report but also asks you to help shape next years' Quality Report by sharing your views and contacting Corporate Affairs via;

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

Availability of the Quality Report

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

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