City Hospitals Sunderland chs

City Hospitals Sunderland NHS
NHS Foundation Trust

Quality Report 2013/14

Contents

A guide to the structure of this report

The Quality Report 2013/14 is an annual review of the quality of services provided by City Hospitals Sunderland NHS Foundation Trust during 2013/14. It is required by Government in an effort to strengthen and maintain the focus on quality of care for patients.

The Quality Report has a number of different sections;

- **Part 1** is a statement about what quality means to City Hospitals Sunderland, signed by the Chief Executive.
- **Part 2** highlights the Trust's performance in 2013/14 compared to the priorities that were agreed and published in last year's report. We have detailed how we performed against them and where we have only partially achieved objectives, and outlined our plans to ensure improvements are made in the future. The key priorities for quality improvement in 2014/15 are also highlighted together with how we intend to measure, monitor and report them.

  Legislated statements of assurance from the Board of Directors complete this section.
- **Part 3** provides an opportunity to report progress on additional quality indicators in 2013/14. This also includes performance against key national priorities.
- We have published (unedited) as **Annex One** the statements from our Commissioners, local Healthwatch and the Overview and Scrutiny Committee in response to this Quality Report.
- The Statement of Directors' Responsibilities in respect of the Quality Report is published as **Annex Two**.

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

About City Hospitals Sunderland NHS Foundation Trust

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

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

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

The Trust has an annual income of £324.32m and fixed assets of £201.42m. It employs 4,400.31 FTE staff or 4,925 headcount as at 31 March 2014.

Part 1: Statement on Quality from the *Chief Executive*

Welcome to our Quality Report for 2013/14. Our aim is to provide a balanced and honest report on how we did last year against the quality priorities we set ourselves. It also provides an opportunity to clearly set out what our plans are for the coming year.

We are seeing a growing number of patients every year and our aim is to treat each one as an individual, to understand what they are going through and to fulfil their expectations of compassionate care in a clean, safe and comfortable hospital. I believe that most of the time we are doing this and the content of the Quality Report 2013/14 will go some way in confirming this.

Once again, we have faced another challenging year for the Trust. The relentless drive to improve patient safety and quality of care continues with the realities of increased activity and demand for financial savings.

The Francis Report into failings of care at the Mid Staffordshire NHS Foundation Trust and the Keogh Review (which examined hospitals with high mortality) have provided a blueprint for how we culturally refocus the service to ensure that it is safer, more caring and more compassionate. No one who works within the NHS or provides health or social care can be in any doubt about the significance of both reports. They demand that the NHS assures itself that it is doing enough to protect patients from harm and to provide the very best care possible at all times.

During 2013/14 we have reflected and acted on the recommendations from Francis and Keogh and I hope the Quality Report gives you confidence and assurance that we are meeting, most of the time, your expectations of compassionate care in a clean, safe, comfortable and friendly hospital. That is not to say that we always get it right. It is important to acknowledge that there is more we can and should do, and the Quality Report will set out what these areas are.

Our successes

I mentioned last year that the Trust had embarked on a huge clinically-led change programme called 'Safe and Sustainable Emergency Care' to reform the whole of our emergency care pathways. That reform work has continued throughout 2013/14, at the same time as the small matter of changing our hospital information system, and I'm delighted to say that we are beginning to see some of the changes necessary to match our ambition of 'fit for purpose' emergency care. We also coped extremely well during our traditional 'winter pressures' period despite intense pressure on our emergency services.

The provision of our first Endovascular Unit for patients with arterial disease is another example of facilities that can only be described as 'state of the art'. The new facility will use technologies that put us firmly at the leading edge of medical innovation.

In December 2013 we had our annual unannounced visit from the Care Quality Commission. The inspection team spoke with patients and their visitors about their experience of the accident and emergency department, care of the elderly wards, outpatients and human resources department. We are delighted that they found no concerns regarding the standards of care we provide.

In 2013/14 we have had our best year to date in reducing cases of MRSA bacteraemia and C. *difficile* infection and every one of us has played some part in that success. Other notable improvements include a welcome reduction in patient falls that cause harm and a downward trend in hospital acquired pressure ulcers.

We have been able to achieve the majority of our Commissioning for Quality and Innovation (CQUIN) targets in 2013/14, or have been able to demonstrate improvements where targets have had to be re-adjusted. We are also delighted to have on-going positive patient feedback in the national 'Friends and Family Test'. Our participation rates and net promoter scores are some of the best in the region, if not the country.

Similarly, we had many positive messages from our own staff in the annual staff survey.

May 2013 was also a watershed moment for the Trust. For those staff reading this report it may seem strange to report as a highlight our implementation of Meditech Version 6, which replaced our entire hospital information system. Clearly it was a huge technical challenge and the magnitude of the undertaking, although not underestimated, did prove to be larger than expected. For those who use it, day to day life was never the same and I acknowledge the operational difficulties it has presented to our staff. We have been working hard to minimise and mitigate any impact to patients, although this has not always been possible. However, I'm confident that once these issues have been resolved, and functionality is embedded into our daily work, we will have an IT system that will safely and effectively manage our complex business. In addition and perhaps more importantly, I hope patients will also see and feel the benefit as they come into contact with our services.

Our disappointments

The results of our patient satisfaction surveys show some stubborn areas where we have not been able to achieve the level of improvement we want. Despite extensive efforts, patients have again rated the Trust low regarding choice of food, although the scores have actually got better. There has also been a small, but welcome, improvement in scores for pain management but we know we still need to do better. And that is why we still have these as priorities next year.

Some of our mortality information suggests that we have higher rates than other Trusts in the region. These have played some part in raising our risk profile. However, mortality is a complex area and there are a number of factors which account for the variation in different mortality measures that we need to understand. We are currently reviewing the context of our mortality measures. We will also be introducing a Trust wide mortality panel to help us understand the clinical and organisational factors which have an impact on patient deaths.

Going forward

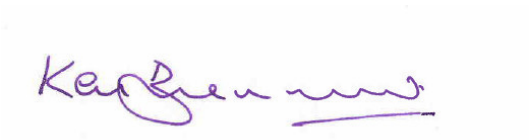
The Trust recognises that to provide high quality services, our staff need to feel engaged, respected, listened to and appreciated. It is our determination that this will be a focal point of the Trust's work. We will look forward to the outcomes of the new staff Friends and Family Test in making sure that we put them at the centre of everything we do.

Finally, I have also been encouraged by the very constructive relationships we have been able to build with our local Clinical Commissioning Groups (CCGs), which officially came into existence on 1 April 2013. The creation of CCGs and the close involvement of GP colleagues in commissioning healthcare services bring new opportunities for us to improve health and wellbeing for local people.

Going forward, we will work closely with our CCG colleagues and other key partners on quality performance and the provision of integrated care to ensure that, together, we can respond effectively to the needs of patients and our local population.

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

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



KEN BREMNER

Chief Executive **Date: May 2014**

Part 2 Priorities for improvement and statements of assurance from the board

2.1 Review of Quality Improvement Priorities 2013/14

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

The table below summarises the priorities and objectives we set for 2013/14; this is followed by a detailed account of our progress and achievements to date.

Priority 1: - Treating and caring for patients in a safe environment and promoting 'harm free' care

	Patient safety
1	Reduce the number and severity of hospital acquired pressure ulcers
2	Increase the number of 'near miss' incidents reported by staff
3	Improve staff recording, recognition and response to deteriorating Early Warning Scores (EWS)
4	Reduce the number of serious patient falls
5	Reduce the number of drug administration errors
6	Maintain the Trust's position of having a low rate of mortality

1. Reduce the number and severity of hospital acquired pressure ulcers

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

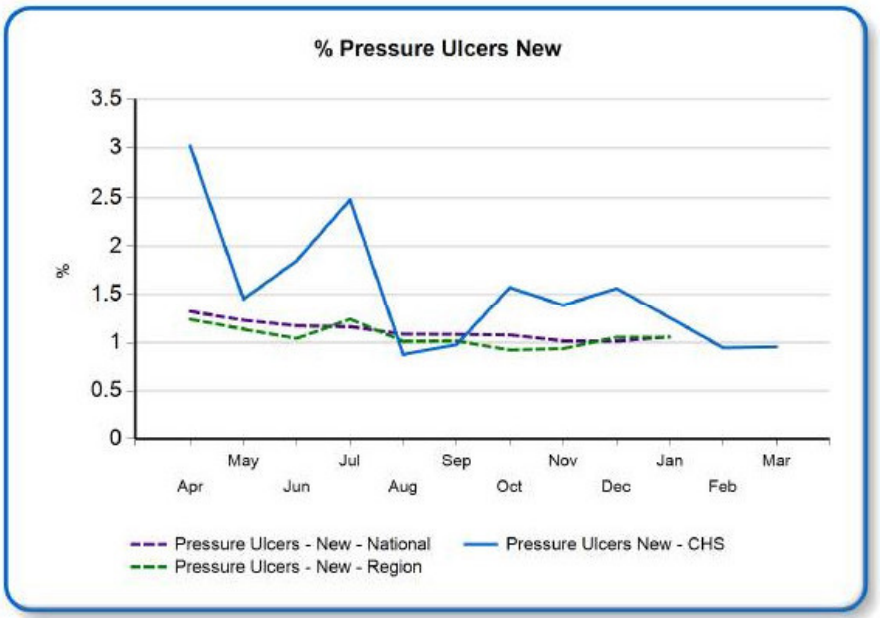
Since July 2012 we have been collecting data for the NHS Safety Thermometer which is a national benchmarking tool for measuring improvement in the reduction of 'harm' to patients. One of the key harms is pressure ulcers.

The table below shows data submitted to the Safety Thermometer from initial collection in July 2012 until March 2014 for 'all' (includes patients with admitted ulcers and those hospital acquired) and 'new' (hospital acquired only) pressure ulcers.

Metric	Apr 12	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Pressure ulcers - All (%)	*	*	*	11.50	8.71	6.09	6.77	5.89	5.26	7.28	3.76	5.91
Pressure ulcers - New (%)	*	*	*	4.84	2.77	2.49	2.92	1.92	2.43	2.38	1.30	1.51
Metric	Apr 13	May 13	June 13	July 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Pressure ulcers – All (%)	7.63	6.10	5.70	8.61	6.71	4.48	4.43	5.83	6.97	6.57	6.21	7.09
Pressure ulcers – New (%)	3.02	1.45	1.85	2.48	0.87	0.98	1.57	1.39	1.56	1.26	0.94	0.95

* NHS Safety Thermometer data collection commenced in July 2012

The graph shows a clear downward trend of patients developing 'new' pressure ulcers, specifically for the period April 2013 to March 2014 and whilst this is in line with regional and nationals trends, the rate of improvement for City Hospitals is more pronounced. Some of our patients are admitted with existing pressure ulcers and our Tissue Viability Specialist Nurse continues to liaise with colleagues across the community to identify specific themes and trends.



Source – NHS Patient Safety Thermometer (Health & Social Care Information Centre)

The number of patients with hospital acquired pressure ulcers is decreasing, evidence that the work of the Trust Tissue Viability Team is having a beneficial impact on patient care.

The table below shows the number of grade 3 and 4 pressure ulcers for each month reported as 'serious incidents'. Pressure ulcers graded 3 and 4 are the most serious types of ulcer and require specialist treatment and management. Each case is examined carefully and the root cause established. There has been some variation in incidents reported during the year but we are committed to improving our prevention and management practices.

2013/14	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
Pressure ulcer grade 3	3	5	1	5	1	3	1	2	2	3	2	1	29
Pressure ulcer grade 4	1	1	2	3	0	3	1	0	2	3	1	1	18
Grand Total	4	6	3	8	1	6	2	2	4	6	3	2	47

Source: Strategic Executive Information System (**STEIS**) information

What we have done during 2013/14:

- the Trust Tissue Viability Team continue to work with wards to implement the SSKIN Bundle (a model of care for pressure ulcer prevention and treatment) and all patients admitted with a pressure ulcer are reviewed by a Dietitian,
- the Trust has introduced a 'STOP Pressure Ulcers' campaign to provide a focus for raising staff awareness about the promotion of pressure ulcer prevention,
- the Nutrition Steering Group has implemented the provision of supplementary snacks, fortified milks and methods of increasing calorific intake for patients at risk of pressure damage,
- meetings have been held with the surgical Sisters / Charge Nurses and Theatre Manager to agree a process for sharing information about the 'at risk' profile of patients at handover. The Theatre

Team also has pressure relieving devices available in theatre to minimise damage to patients' pressure areas during the perioperative phase,

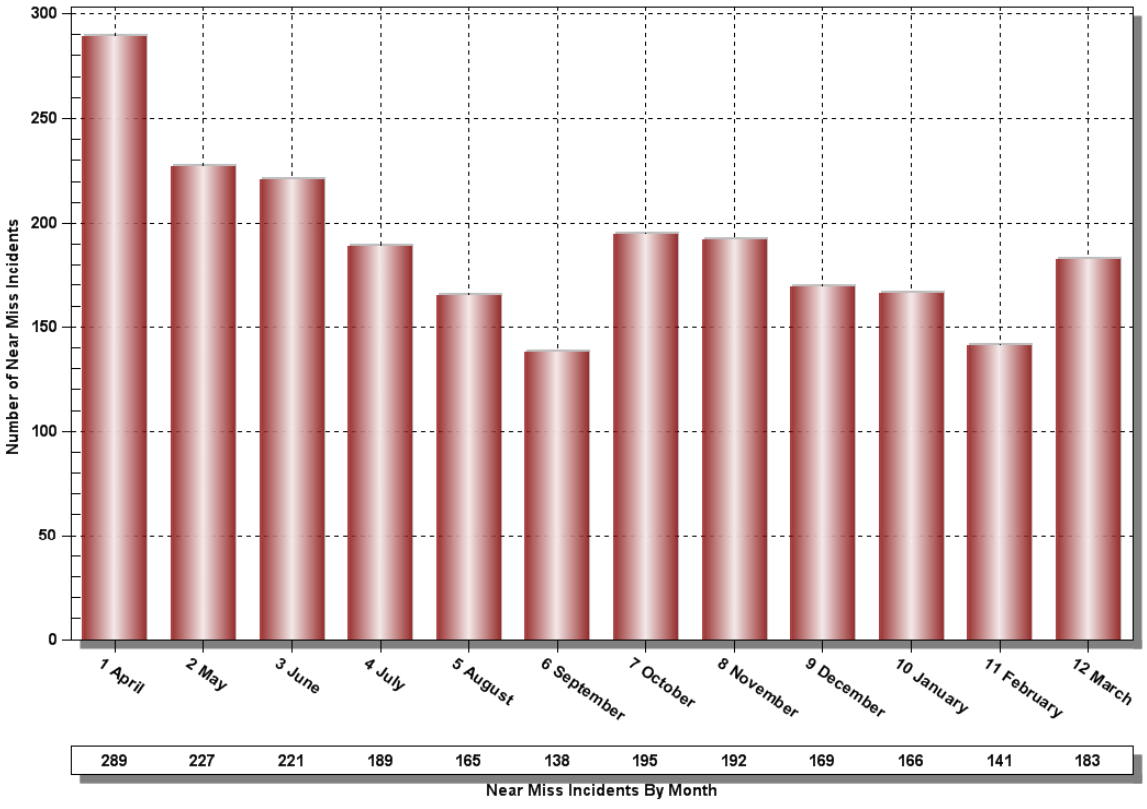
- a series of meetings have also been held with Sisters / Charge Nurses where the prevalence of patients with pressure ulcers is higher to identify any further actions that can be taken. Additional ward based teaching sessions are being provided by the Tissue Viability Specialist Nurse. There is also a programme of spot audits of patient risk assessments and wound management practices, and
- the Executive Committee has agreed additional investment to enhance the current Tissue Viability Team which will allow the Trust to provide a comprehensive seven day service.

2. Increase the number of 'near miss' incidents reported by staff

Near miss reporting indicates a positive safety culture, in which staff are able to anticipate safety issues before there is harm to a patient. The Trust is encouraging staff to report near misses so it can learn and put actions in place to prevent patient harm.

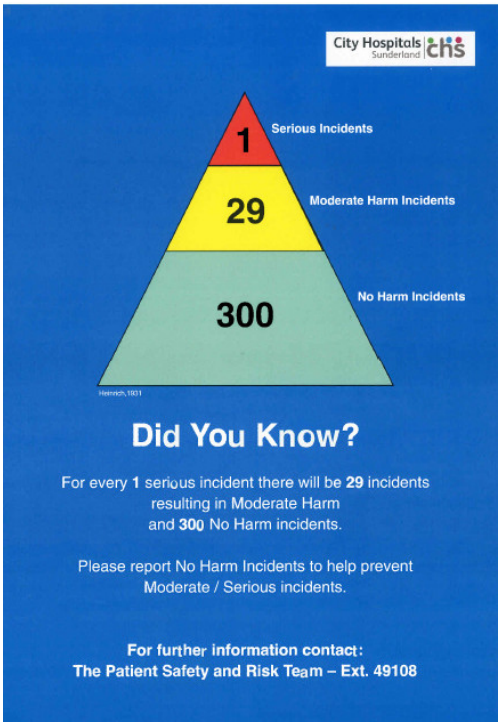
The Patient Safety and Risk Team have worked with teams across the Trust during 2013/14 to stress the importance of near miss incident reporting and to assist in thematic analysis and prevention of more serious incidents. Last year we launched a Trust-wide campaign to 'Keep calm and carry on reporting incidents' and had intranet screen shots promoting the importance of incident reporting. We have started to see the benefits of these initiatives positively affecting staff reporting behaviours but we know we cannot be complacent.

To help staff understand the term 'near miss' we have renamed these incidents as 'no harm'. City Hospitals Sunderland's degree of harm profile is different from other Trusts. The main difference is that the organisation records fewer incidents with no harm. However, the Trust profile in 2013/14 has begun to change. The chart below shows the number of near miss incidents reported each month for 2013/14. When compared with the numbers reported during 2012/13 there has been a steady increase overall although there has been some variation noted this year.



	Apr 12	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Number of near miss incidents	56	75	69	101	78	93	142	147	92	97	114	131
	Apr 13	May 13	June 13	July 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of near miss incidents	289	227	221	189	165	138	195	192	169	166	141	183

Source – City Hospitals Sunderland Safeguard incident system



The Patient Safety and Risk Team launched a poster campaign using Heinrich's Triangle (1931) to assist in the visualisation of why it is important to know about and act to improve no harm incidents, and to prevent more serious incidents from occurring.

An example of an action taken where no harm incidents have been submitted below:

- Analysis of patients leaving the ward (without permission) and therefore reported as missing, but no harm has come to them. A risk manager was allocated to work with the wards/departments most frequently reporting these incidents. Risk assessments of the environment were updated and security measures reviewed with reasonable adjustments made to promote safety. We will be evaluating the impact of these measures next year.

During 2014/15 the Patient Safety and Risk Team will be using the Staff Safety Survey results to develop incident reporting awareness, specifically with the administration and clerical staff and support teams. There are also plans for specific seminars for these groups of staff and the development of trigger lists to assist their understanding of incident reporting. Following discussions with the Portering Team Manager a dedicated answer phone will be available for the porters to use as an incident reporting system. We will also continue with our high level learning messages which go out to the organisation each week from the Rapid Review Group, which we started this year. This group review all reported serious incidents and patient safety concerns.

3. Improve staff recording, recognition and response to deteriorating Early Warning Scores (EWS)

In the Trust, an early warning score system is in place to help identify patients whose condition may suddenly deteriorate. Incidents reported by staff, information from our local audits and reviews of mortality cases have sometimes shown that patient observations were not always recorded in a timely manner and that, on occasion, patient's early warning scores were not acted upon in time to prevent further problems.

The Trust began the roll out of the new National Early Warning Score (NEWS) in September 2013 which also coincided with a revised hospital observation chart. The same principles apply to the new model in providing a simple trigger for escalation of care if the patient's condition deteriorates. The introduction of the revised NEWS tool has been a significant undertaking by the Trust, which involved widespread training

of staff on relevant wards. The findings from the annual audit show that most of the good practice around EWS has been maintained, although documentation regarding the patient's monitoring plan has slipped. It is expected that this will improve with further training and staff being more competent and confident with the national revised tool.

The Trust undertakes an annual Trust wide audit of how the NEWS system is working and some of the results, compared to previous years, are highlighted below:

Indicator	08/09	09/10	10/11	11/12	12/13	13/14
National Early Warning Score (NEWS) was recorded accurately	81%	91%	95%	94%	92%	92%
Patients with a documented monitoring plan	*nm**	77%	93%	97%	94%	83%
Patients had the minimum required frequency of observations / NEWS in accordance with their level of care	*nm*	*nm*	*nm*	96%	94%	91%
Monitoring plans were adhered to overnight	*nm*	79%	72%	83%	78%	78%

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

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

The annual audit showed that compliance with monitoring plans appeared to reduce slightly overnight. Further work will be undertaken next year to review the factors that may have contributed to this. Staff training in NEWS will then be modified and the 2014/15 audit will be assessing any improvement in performance.

NEWS has not been introduced in paediatrics and obstetrics as it is not validated for children or pregnant women. A pocket size aide memoire NEWS chart is also available for ward teams.

Although the indicator is not a priority for 2014/15, the results from the annual Trust wide audit of NEWS will continue to be monitored by the Deteriorating Patient Group.

4. Reduce the number of serious patient 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, and these may decrease the likelihood of a return to previous levels of independence for patients with a prolonged hospital stay. 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 Hospital Based Falls Group has worked throughout 2013/14 with clinical teams to assist in the identification of patients who are at risk of falling and to introduce measures to mitigate harm. There have been three main tools we have used to assist in the work namely incident reports, the NHS Safety Thermometer data and the Royal College of Physicians Fall Safe Pathway.

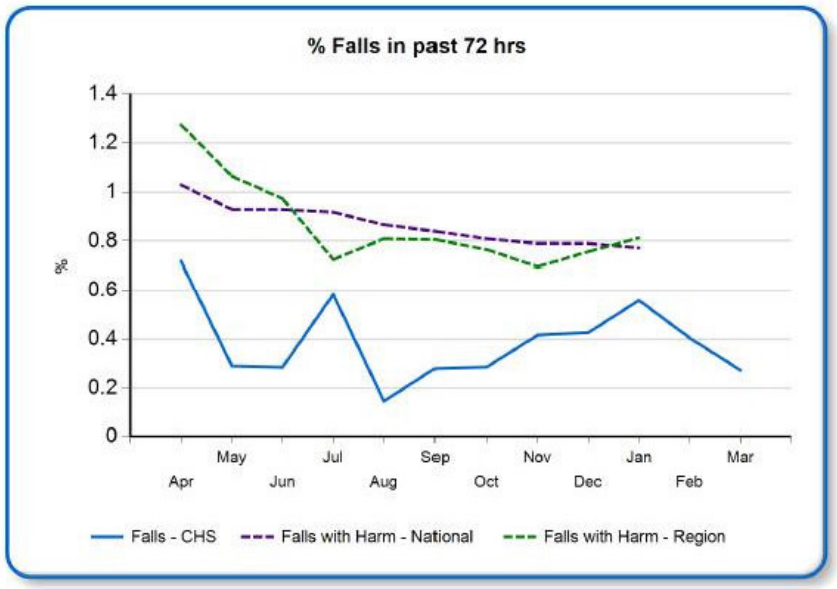
By analysing incident reports and root cause analysis investigations alongside the NHS Safety Thermometer data we have been able to pin point 'hot spots' for patient falls and work with the clinical teams to identify mechanisms to reduce harm to patients. Introducing the Fall Safe Pathway has enabled clinical staff to use the tool to identify patients at risk. Following the launch of Meditech V6 and upgraded electronic patient record in May 2013 we successfully embedded the Fall Safe assessment tool into the system, alongside the bed rail assessment and patient information leaflets. Ward Managers are now able to use this system to complete patient risk assessments and apply specific care plans. This is further supported by a monthly quality assurance check by Matrons.

The NHS Safety Thermometer data provides the Trust with information about patients at risk of falls. Our performance has improved since data collection commenced in July 2012 and is better than the North East regional benchmark and national average. The table below shows performance from this current year (April 2013 – March 2014), and for the preceding year, for falls that have caused harm.

	Apr 12	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Falls with Harm (%)	*	*	*	0.78	1.11	1.25	1.33	0.68	0.81	0.53	0.29	0.41
	Apr 13	May 13	June 13	July 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Falls with Harm (%)	0.72	0.29	0.28	0.58	0.15	0.28	0.29	0.42	0.43	0.56	0.40	0.27

* NHS Safety Thermometer data collection commenced in July 2012

The chart shows an improving trend throughout 2013/14 for falls that cause harm in the past 72 hours and is below the regional and national profiles (lower percentage rate is better).



Source – NHS Patient Safety Thermometer (Health & Social Care Information Centre)

The table below shows the actual numbers of slips, trips and falls that have been reported during 2013/14 and how the totals compare with previous years. The Trust hasn't been able to show any reduction in the number of falls but we continue to encourage staff to report all incidents where patients have a slip, trip or fall.

2013/14	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
Slips, trips and falls	166	163	122	155	148	130	172	151	153	141	105	137	1743
	2011/12 = 1645						2012/13 = 1720						

What we have done about patient falls during 2013/14

- wards have introduced comfort rounds to ensure that patients are regularly checked to see if they require additional assistance and support, such as patients being escorted to the toilet, providing analgesia, drinks and positional changes. Where the number of falls has reduced it is attributed to a combination of comfort rounds and the Fall Safe programme,
- the Hospital Based Falls Group was successful in introducing special slippers for patients who are assessed at risk. These have non slip soles and a terry towelling sock and can be worn in bed. Many

patients have commented how comfortable they are and how they provide reassurance when getting out of bed,

- a visual prompt of a magnetic falling star is placed by nursing staff above a patient's bed when they are at risk of falls and require additional supervision and support, and
- all improvements are developed and monitored by the Hospital Based Falls Group which is a sub-group of the Clinical Governance Steering Group.

5. Reduce the number of drug administration errors

In advance of the Meditech V6 upgrade we wanted to create a system to enable drug errors to be reported through the Trust Safeguard Incident Reporting System which would be linked to the new hospital information system. This would enable accurate reporting and actions to be taken to mitigate against future risks. Unfortunately, the capability within the new system to progress this priority has not happened as we expected and we made a decision to postpone this work until later in 2014. A sub-group of the Clinical Governance Steering Group is assigned to this work and we hope to be in a better position to report progress next year where it has been identified as a priority for 2014/15.

6. Maintain the Trust's position of having a low rate of mortality

Performance and progress against this indicator can be found in Part 3: Review of Quality Performance 2013/14.

Priority 2: - Enhance the quality of life of patients with long term conditions: improve the in-hospital management of patients with Dementia

The following are the quality priorities identified for 2013/14.

	Clinical effectiveness
1	Patients assessed as 'at-risk' of dementia will have diagnostic assessments, investigations and appropriate follow-up
2	Dementia patients are assessed on their risk of developing malnutrition and dehydration on admission (MUST score)
3	Reduce length of stay of patients with dementia
4	Appropriate training of staff who care for patients with dementia
5	To ensure that carers of people with dementia feel supported
6	Reduce the number of falls and serious injury, particularly among those patients with dementia

1. Patients assessed as 'at-risk' of dementia will have diagnostic assessments, investigations and appropriate follow-up

The National Dementia Strategy (2009) outlined the best practice standards required to help patients and their families who are living with dementia. The Commissioning for Quality and Innovation (CQUIN) indicator for dementia care was also introduced to incentivise the identification of patients with dementia and to prompt appropriate referral and follow up after they leave hospital. In order to achieve the CQUIN target, the Trust was required to achieve 90% compliance from April 2013-March 2014. Trust performance for 2013/14 shows that we have met and exceeded the CQUIN measure.

2012/13*	Indicator No.	Description	Performance	Target
Qtr 3	1	Dementia - Find & assess	56.9%	90.0%
	2	Dementia - Investigate	100.0%	90.0%
	3	Dementia - Refer	65.3%	90.0%

2013/14	Indicator No.	Description	Performance	Target
Qtr 4	1	Dementia - Find & assess	97.7%	90.0%
	2	Dementia - Investigate	100.0%	90.0%
	3	Dementia - Refer	95.5%	90.0%
Qtr 1	1	Dementia - Find & assess	96.7%	90.0%
	2	Dementia - Investigate	100.0%	90.0%
	3	Dementia - Refer	100.0%	90.0%
Qtr 2	1	Dementia - Find & assess	99.75%	90.0%
	2	Dementia - Investigate	100.0%	90.0%
	3	Dementia - Refer	98.65%	90.0%
Qtr 3	1	Dementia - Find & assess	98.68%	90.0%
	2	Dementia - Investigate	100.0%	90.0%
	3	Dementia - Refer	100.0%	90.0%
Qtr 4	1	Dementia - Find & assess	99.8%	90.0%
	2	Dementia - Investigate	100.0%	90.0%
	3	Dementia - Refer	100.0%	90.0%

* Data collection commenced October 2012 with a target of 90% placed across all 3 indicators

2. Dementia patients are assessed on their risk of developing malnutrition and dehydration on admission (MUST score)

The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. The goal during 2013/14 was to try and assess whether patients specifically diagnosed with dementia had their MUST score reported on admission. Unfortunately, we have been unable to utilise the Meditech Version 6 programme to report specifically on dementia patients. However, a generic Trust-wide audit was undertaken by Dietetic colleagues on the use of the MUST screening tool during 2013. Data was collected from 71 patients across a range of inpatient wards.

In order to calculate a MUST score, a patient's weight, height, body mass index (BMI), percentage unplanned weight loss and acute disease state should be recorded. The results below show that weight, height and BMI were recorded between 89% and 90% of patients. The percentage weight loss (49%) and disease state (41%) were not recorded as frequently.

	Yes	No	Unable to assess	Not documented
Weight	89% (63)	11% (8)	-	-
Height	89% (63)	8% (6)	3% (2)	-
BMI	90% (64)	8% (6)	1% (1)	-
Percentage weight loss recorded	49% (35)	37% (26)	7% (5)	7% (5)
Disease state	41% (29)	51% (36)	3% (2)	6% (4)

Following assessment 57% of patients warranted a dietetic referral. The results showed that of these patients only 27% were actually referred to dietetics. However, the enhanced functionality of Meditech Version 6 has changed the documentation of the MUST screening tool and referral pathway to dietetics. As the system gives staff a prompt to refer patients with a MUST score of 2 or more ('at risk' patients) we expect the rate of referral to increase for those patients in 2014/15.

This is a priority for 2014/15 and we will ensure that the Meditech system provides us with the necessary information about whether the MUST tool is being routinely used with dementia patients throughout the organisation.

3. Reduce length of stay of patients with dementia

People with dementia stay far longer in hospital than other people who are admitted for the same procedure. The longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual's physical wellbeing. City Hospitals has a specific ward dedicated to the care of people with dementia and those with cognitive frailties. There is also a special team known as the Dementia & Delirium Outreach Team (DDOT) which provides specialist guidance for those who look after dementia patients on other wards in the Trust. They also provide important support for families and carers.

The table below shows that during 2013/14 our average length of stay for patients with dementia has improved and is better than the average for the North East. This achievement will have been, in part, due to knowledge, skills and expertise within the dementia ward supported by DDOT.

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
City Hospitals Sunderland (performance measured in days)											
12.24	13.89	15.01	12.44	15.25	15.47	11.40	13.75	15.37	14.44	15.99	15.07
North East Peers (performance measured in days)											
12.99	14.07	12.24	14.13	13.76	13.61	13.55	12.18	13.49	14.04	15.44	14.33

Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
City Hospitals Sunderland (performance measured in days)											
13.36	14.59	12.68	13.91	11.03	11.91	13.11	13.69	11.10	13.30	12.58	11.87
North East Peers (performance measured in days)											
14.12	13.65	13.28	13.65	13.09	12.17	12.54	12.69	12.58	*	*	*

* North East peer data is currently unavailable for the final quarter of the year

4. Appropriate training of staff who care for patients with dementia

People with dementia are some of our most vulnerable patients and being in hospital can be the most unnatural and confusing care environment. By creating a workforce which understands dementia and which has the knowledge, confidence and skills to care for people with dementia, the overall experience and stay in hospital can be greatly improved. For example, staff working with people with dementia should be trained in effective approaches to confusion, agitation or aggression, including calming or distracting techniques.

At City Hospitals, basic dementia awareness training has been delivered at induction for Health Care Assistants for the last 2 years. This education has been specifically around the use of screening tools, how to use individualised care plans and the actions outlined in the national dementia strategy.

In addition, dementia education has been delivered through a number of study days, for example, Dignity in Dementia sessions and Vulnerable Adults training. Medical staff have received education at induction by the Dementia lead clinician, who has also delivered education to Matrons and staff in Directorates through their clinical governance meetings. During 2013/14 the numbers of hospital staff who have undertaken dementia training are as follows:

e-Dementia – online training	29
e-Dementia: Introduction to Dementia	77
The Open Dementia Programme	7
Insight into Confusion Training (Dementia)	94
Total	207

The first of the sessions to be delivered by the newly appointed Delirium and Dementia Outreach Team (DDOT) was delivered in July 2013. This training entitled 'Insight into Confusion' is being delivered at 3 levels – basic, intermediate and advanced depending on the target audience.

5. To ensure that carers of people with dementia feel supported

People with dementia can feel vulnerable as their condition progresses and they increasingly rely on other people to do things for them. It is important that people who have dementia feel reassured and supported, while retaining some level of independence.

The support of carers of people with dementia formed part of the national CQUIN priorities for 2013/14. The requirement for the Trust was to demonstrate that they had undertaken regular audits of those caring for people with dementia to assess whether they feel supported.

The Dementia Carers' Survey was developed and implemented by the Dementia and Delirium Outreach Team (DDOT). The original aim was to survey 20 carers per month to find out about their experiences. This proved to be a difficult target to achieve and despite strategies put in place to try and improve the uptake, including simplifying the questionnaire and assigning a member of the DDOT to help with the process, we were never able to reach the required numbers. However, from the small numbers of questionnaires that were completed carers reported they did feel they were supported in caring for their relative.

The table below illustrates the generally low rates of responses to the survey for the year.

	Q1	Q2	Q3	Q4
Number of surveys issued	20	60	12*	9
Number of responses	2	2	4	1

* process changed at this point

Changing the process for 2014/15

To improve how we get feedback from carers in 2014/15, we have agreed to take a different approach. A series of semi structured interviews will take place with carers looking at various aspects of dementia care from the carer's perspective. DDOT will proactively identify patients with dementia who have a suitable carer. Using this format will allow a greater amount of qualitative information to be gathered, in an objective, unbiased format.

In addition, a follow-up telephone interview will take place with the patient's carer (with their explicit consent) shortly after discharge to consider aspects related to the discharge process, and general support and aftercare.

Looking towards the future, with the development of the new dementia centre in the Trust, we will have the facility to run carer drop in sessions, both for carer education, and as a mechanism for obtaining carer feedback.

6. Reduce the number of falls and serious injury, particularly among those patients with dementia

People with dementia are four to five times more likely to experience falls than older people without significant cognitive impairment. People with dementia can have impairments with memory and difficulties with orientation and judgement which together increase the risk of unsafe wandering and falling. We wanted to reduce avoidable slips, trip and falls for this vulnerable group of patients. However, we have been unable to develop the electronic solution required to identify these patients which was reliant on the integration of our existing systems with Meditech V6.

One of our priorities in 2014/15 is to adapt the hospital environment for patients with dementia, where it is possible, in order to promote a more 'dementia-friendly' environment. This will help in creating safe areas for dementia patients who are vulnerable to wandering and falls.

Priority 3: - Ensure that we give compassionate care and people have a positive hospital experience

These are the quality priorities identified for 2013/14.

	Patient experience
1	Improve the likelihood that patients would recommend our services to their family and friends
2	Increase the proportion of patients who feel listened to and involved in their care
3	Enhance the patients perception of pain management, i.e. reduce number of delayed / omitted analgesics
4	Offer all patients a choice of food
5	Ensure patient feedback is acted on
6	Improve end of life care through implementation of the 'Deciding Right' regional framework
7	Training of staff in compassionate care

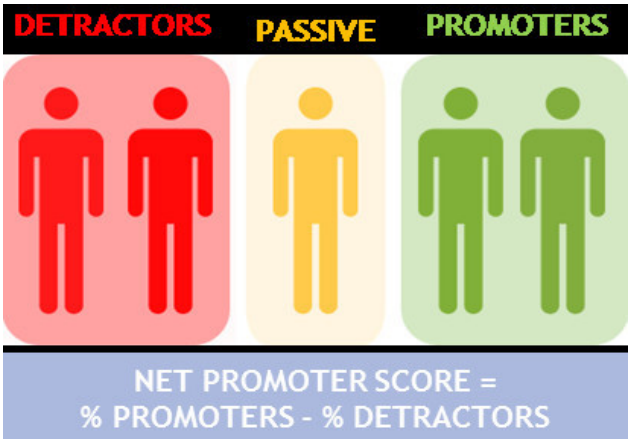
1. Improve the likelihood that patients would recommend our services to their family and friends

The national Friends and Family Test (FFT) aims to provide a simple headline indicator of patient experience which can be used by organisations to improve patient experience. Since April 2013, the FFT question has been asked in all NHS inpatient wards and A&E departments across England and, from October 2013, all maternity services have also been asking women the same question at different points throughout their care:

"How likely are you to recommend our (ward/Accident & Emergency department/maternity service) to friends and family if they needed similar care or treatment?"

Responses are recorded on a scale of extremely likely to extremely unlikely.

Hospitals are encouraged to follow up patients' responses with further questions about why they answered in the way they did, making sure that every patient, including every pregnant woman using maternity services, has the opportunity to be heard. The results are made available to individual wards as well as being published at monthly intervals on the NHS Choices websites with the aim of improving care.



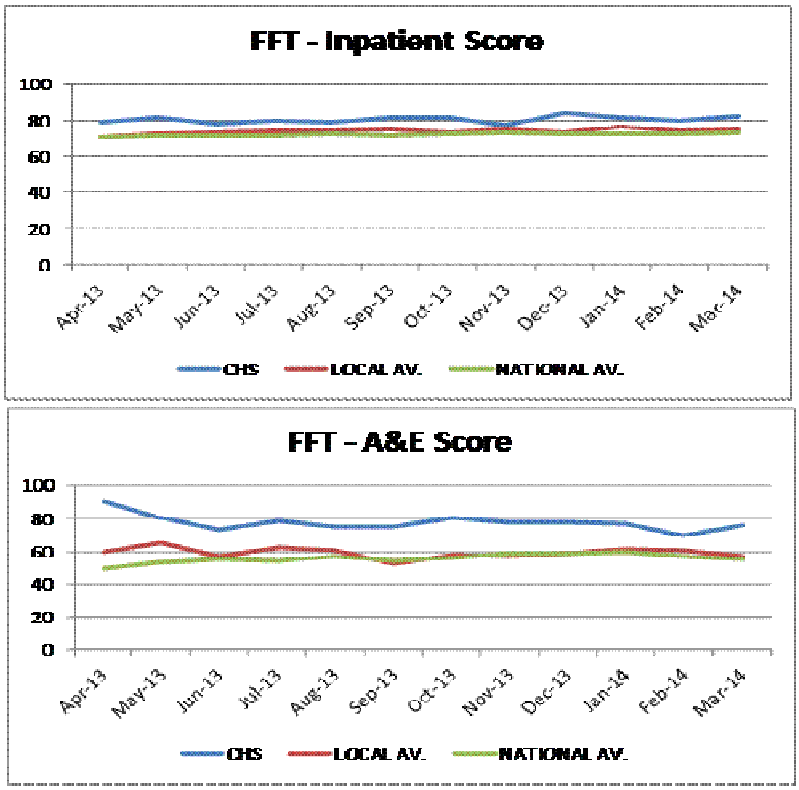
The FFT scoring is complex, but is calculated by analysing responses and categorising them into promoters, detractors and neutral (passive) responses. The proportion of responses that are promoters and the proportion that are detractors are calculated and the proportion of detractors is then subtracted from the proportion of promoters to provide an overall **'net promoter'** score. Those that say they are 'extremely likely' are counted as promoters. 'Likely' is neutral, 'neither unlikely nor likely', 'unlikely' and 'extremely unlikely' are all counted as detractors.

The 'net promoter' score is shown on a scale from -100 (poorest experience) to + 100 (best experience). The FFT scores are benchmarked nationally and are accessible to the public to use (if they wish) to make

choices about where they receive health care. The tables and charts below show that City Hospitals has a net promoter score which is higher than the local (other peer hospitals) and national average for both inpatients and Accident & Emergency departments.

Scores 2013/14	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient	79	81	78	80	79	81	81	77	84	81	80	82
National average	70.8	71.8	71.8	71.5	72.2	71.8	72.6	73	72.1	72.7	72.4	73.1
Accident & Emergency (A/E)	90	80	73	79	75	75	80	78	78	77	70	76
National average	50	52.9	55.6	54.5	57	54.6	56.4	58.5	58.8	59.5	56.8	55.1

CHS Friends and Family Test net promoter scores (Scale -100 to +100)



Source – NHS England (Friends and Family Test data)

Patients are also given the opportunity to provide additional comments and this information, as well as the ward level scores, is being shared with ward managers who use it to make improvements where necessary. Some examples include;

- *"The nurses were very attentive. Great care",*
- *"The care was excellent. Staff very helpful",*
- *"Every member of staff were so professional. A smile and a supportive word is always available on the ward. Thank-you",*
- *"I was looked after by all the staff and were all very friendly",*
- *"The food was great. The nurses are fantastic. Staff nurse J is outstanding looked after me and was excellent. Food was very well catered for",*
- *"SC always put my mind at ease and answered any questions with a smile",*
- *"Communication between doctors and ward staff could be better otherwise all good",*
- *"In some cases verbal communication concerning treatment could be better",*

- *"Time waiting for treatment is too long", and*
- *"Long wait!! Poor information about what was happening until asked several times. Long period in room alone, however when staff did attend very nice, professional and extremely helpful".*

From some of the less positive comments received from patients, we have been able to increase monitoring on the state of the cleanliness of toilets in the Accident and Emergency (A/E) department. Patients also felt that they were waiting too long in A/E and were not given enough information. We have been able to introduce comfort checks and increased interactions with patients in the department so that we can them informed and up to date about what is happening.

Whilst these less positive comments are helpful for identifying areas for improvement, positive comments are also important in letting staff know that what they are doing is well received and they improve staff morale.

2. Increase the proportion of patients who feel listened to and involved in their care

Patients need to feel listened to and involved in their own health, care and treatment. This means being involved in decisions and having choice and control over their care and interactions with health services. The amount of control an individual wishes, or is able to take, may vary according to their background and experience as well as their current circumstances. However, the hallmark of a quality service is one where patients take a more active part in their care. Increasing the proportion of patients who feel listened to and involved in their care has been identified as a priority in the Trust Patient Experience Improvement Plan. The question is asked as part of the annual adult inpatients survey:

		Score 2012	Score 2013
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.2	7.0

Source - National Adult Inpatient Survey 2013 Picker Institute (Care Quality Commission)

A similar question is asked of women who participated in the national survey of women's experiences of maternity services 2013. In terms of our performance compared with other Trusts we were at the high end of amber and 'about the same' as other organisations who took part in the survey.

	Score 2010	Score 2013
Think about your care during labour and birth, were you involved enough in decisions about your care?	8.7	8.7

Source - National Survey of Women's Experiences of Maternity Services 2013 - Picker Institute (Care Quality Commission)

We will continue to promote the importance of involving patients in decision making and aspects of their care with our nursing teams through educational events, supervision sessions and staff development. The introduction of comfort rounds will provide increased opportunities for patients to be more involved in many aspects of their care. We will monitor the extent that patients feel involved in their care through our monthly real time feedback information and from personal comments expressed by patients during Ward Assurance visits.

3. Enhance the patients' perception of pain management

Whilst everyone has experience of pain it is often complex and poorly understood. It is subjective and can sometimes be challenging for patients and healthcare staff to assess and manage effectively. Patients have reported in the National Annual Inpatients Survey that they feel that their pain management could have

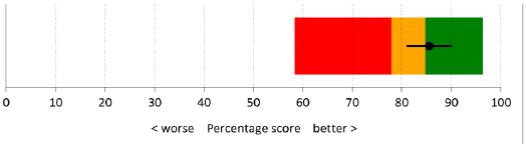
been better, although our local surveys provide a more positive picture. The latest national adult inpatient survey (2013) has shown a small improvement in our score compared to last year and moved our comparative position from a red 'worse' than other Trusts to an amber 'same as' category. Whilst this is a welcome improvement we feel that further progress still needs to be made to this important area of practice.

		Score 2012	Score 2013
Q39	Did you think the hospital staff did everything they could to help control your pain?	7.5	7.8

Source - National Survey of Women's Experiences of Maternity Services 2013 - Picker Institute (Care Quality Commission)

From our participation in the National Cancer Patient Experience Survey (August 2013), the responses about pain management from patients with various cancer types are even more positive and exceed national scores (for day patients and outpatients). Our position was in the green 'better' than other Trusts. However, the percentage for inpatients was slightly below the national score (82% for the Trust and 85% nationally).

Staff definitely did everything they could to help control pain (Hospital care as a day patient / outpatient)		
Cancer type	**City Hospitals**	**National**
Breast	78%	83%
Colorectal / Lower Gastro	88%	81%
Lung	89%	82%
Prostate	92%	79%
Haematological	85%	84%
Head & Neck	90%	83%
Urological	80%	77%
All Cancers	**86%**	**82%**



Source – National Cancer Patient Experience Survey 2013

We also ask a question about patients' perception of pain in our real time feedback surveys and collectively they do provide further evidence that patients have a positive experience of their pain management. Our performance shows a consistency of over 90% across wards; however the difference in survey methodology between the Trust real time feedback and the National Annual Survey may be a factor in the difference between the sets of results.

What we have done in relation to pain management during 2013/14

- pain is identified as one of the three patient experience improvement priorities for 2013/14 (and 2014/15), and is included in the Trust annual plan. Each Directorate will therefore be taking local action to ensure improvement,
- provision of comfort rounds on selected wards, involving purposeful contact with the patient to assess and deliver care. Early results show the positive impact in managing patients' pain and it has further identified the need to refine pain scores for patients who are cognitively impaired. The model of care will be replicated on other wards throughout the Trust,
- pain is a regular agenda item on the monthly Matrons Operational Meeting to ensure any good practice is shared across the Trust,
- some wards have individual cupboards containing pain relief in each patient bays which can speed up administration,
- a two hour teaching session on pain management is delivered to all newly qualified nurses as part of their Preceptorship Programme. In addition, pain management is included in the Healthcare Assistant (HCA) Development Programme which is mandatory for all newly appointed HCAs,

- the Patient Experience Symposium held in October 2013 had a focus on pain as one of the Trust's improvement priorities and included lectures, posters and breakout sessions on pain management; and
- a Kaizen improvement event facilitated by the Service Improvement Team is planned for 2014/15.

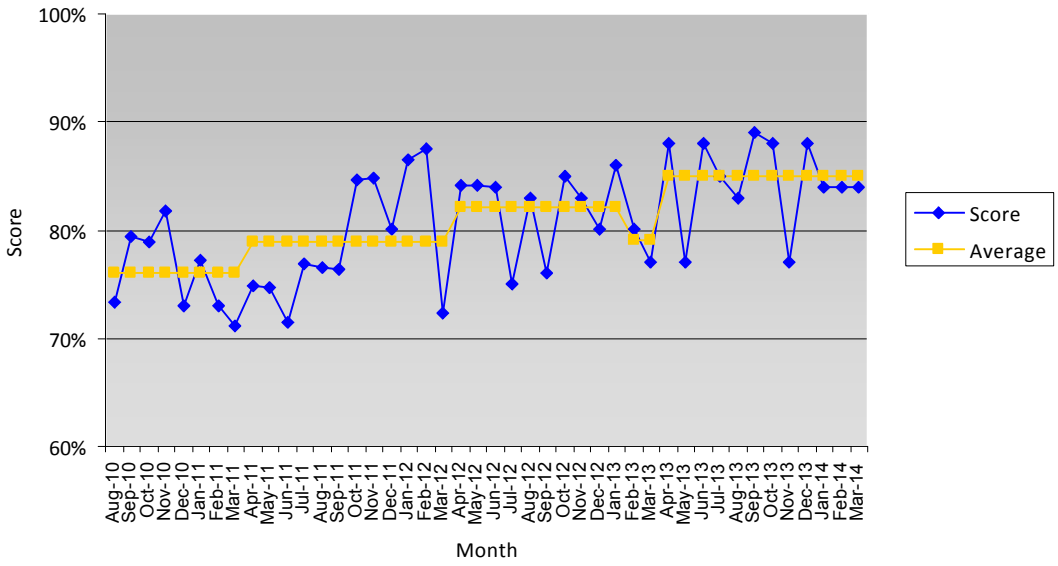
4. Offer all patients a choice of food

Achieving progress with this particular objective has been quite a challenge for a number of years despite a tremendous amount of effort to ensure that patients have a genuine choice at mealtimes. Whilst our local surveys give us confidence that patients are being given a choice, the patient responses in the National Inpatients Survey present a different picture.

The National Inpatients Survey 2013 has shown a small improvement in scores reported by patients, however this gain is lessened by our comparative position remaining in the 'worst' performing Trust category.

Question in national patient survey 2013		Score 2012	Score 2013
Q22	Were you offered a choice of food?	7.7	8.0

In view of its importance this question is also asked in the Trust monthly real time feedback collection. In common with this different approach, i.e. "real time", the scores are much more positive. The chart below shows the aggregated scores from August 2010 – March 2014 and shows clearly incremental, year on year improvement.



There is ongoing work to improve the patient perception of choice of food. All patients are now issued with their own menu which they retain for the duration of their time in hospital. During 2013 we introduced a new patient menu (see below).

Staff have been reminded that "on request" options are also available for patients. As part of the Ward Quality Assurance visits, patients are asked if they have their menu card and also about the choice and quality of their food. A more detailed description of some of our other activities is presented in Section 3.

5. Ensure patient feedback is acted on

Collecting feedback by itself has no value. It needs to be acted upon and used by staff, working within their teams, to identify aspects of their service that need to improve, so appropriate actions can be taken. This is one of the more challenging aspects of the whole area of patient feedback, but one which is crucial to show that the organisation has listened to concerns and that patient experience matters.

There are now a number of different mechanisms in place where patient feedback is reported and assurance given that services have changed:

- Quarterly Risk Management Aggregate Reports which are taken to both Clinical and Corporate Governance Groups and written summary reports presented to the Governance Committee (which are shared with Commissioners);
- Quarterly Real Time Feedback reports which are presented to the Patient Carer and Public Experience Committee (which are also shared with our Commissioners);
- Quarterly Complaints Report presented to the Patient, Carer and Public Experience Committee; and
- Monthly Quality, Risk and Assurance Reports via the governance system to the Board of Directors.

More detailed examples of where patient feedback has led to improvements in care are included in Section 3 under 'Real Time Feedback' and 'Complaints'.

6. Improve end of life care through implementation of the 'Deciding Right' regional framework

Deciding Right is a North East wide initiative to integrate the principles of making advance care decisions for all ages. It brings together advance care planning, the Mental Capacity Act and cardio pulmonary resuscitation decisions into one single framework. It puts the patient at the centre of decision making and reinforces the partnership between the patient, carer and healthcare professional as they support the patient in advancing their wishes, preferences and values. Deciding Right identifies the triggers for making these care decisions in advance.

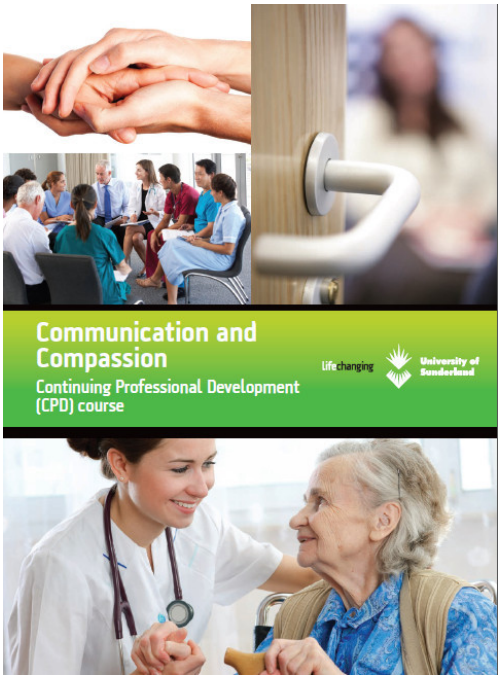
The Trust has worked in partnership with South Tyneside Foundation Trust to develop a structured education plan for the Regional Deciding Right initiative. Monthly training sessions began in September 2013 and are being delivered to nursing staff from directorates across the Trust. There is also a network of 'Deciding Right Champions' who attend the training. These monthly sessions cover national legislation and the principles and documentation of Deciding Right, delivered by the Dementia and Delirium Outreach Team. Additional sessions include the importance of communication which is facilitated by the Specialist Palliative Care Team. The indicator has also been monitored through our Commissioning for Quality and Innovation (CQUIN) Scheme (see section 2.2 'Information on the use of the CQUIN framework').

7. Training of staff in compassionate care

The NHS has an unprecedented focus on quality following the failings of the Mid Staffordshire NHS Trust and the independent Inquiry by Robert Francis QC. In particular, the development of the national strategy Compassion in Care (6Cs – Compassion, Care, Commitment, Courage, Competence and Communication) and publication of subsequent national, regional and local implementation plans, has shown the priority given to this agenda and reinforced the view that 'compassionate care' is everybody's business in the NHS.

Against this background of perceived "failings" by the NHS and a "loss" of caring and compassion in healthcare, there are compelling reasons for developing a strategy for compassionate care. During 2013/14 we have been developing a Compassionate Care-Customer Care Strategy for the Trust. The strategy will provide strategic direction to enable the Trust to drive the cultural change required to ensure genuine patient and family/carer centred care.

The Trust has developed a programme of internal training and workshops and an accredited module with Sunderland University on compassionate care (see below).



Approximately 77 Healthcare Assistants have attended the Trust's Health Care Assistant Programme which promotes compassion in care and the 6-Cs highlighted in the national Compassionate Care Strategy. In addition, 27 Registered Nurses have also undertaken the 'Communication and Compassion Course' at Sunderland University and a number of other staff have completed the 'Compassion in Practice' e-learning package.

Priorities for quality improvement 2014/15

National guidance continues to state that we group 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 upon our performance in 2013/14 as well as taking account of some significant National Reviews and Inquiries that have taken place during 2013. These have included:

- Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England,
- A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick, and
- A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt. Hon Ann Clwyd MP and Professor Tricia Hart.

We have also reflected on the following national and local information sources:

- Trust strategic objectives and service development plans, i.e. OGSM planning framework;
- feedback from external reviews of Trust services, i.e. CQC inspections, CQC Intelligent Monitoring Reports, CCG intelligence, Internal Audit reviews, Clinical Accreditation Schemes and other external audits;
- patient safety issues from the Trust incident reporting system;
- patient, carer and public feedback on Trust services, including Friends & Family Test, national patient surveys and real time feedback;
- learning from complaints, PALS, incidents and quality reviews;
- feedback from patient safety initiatives and staff listening events;
- progress on last year's quality priorities; and
- feedback on last year's Quality Account.

In addition, we have also considered the introduction of the Meditech V6 hospital information project and the impact this has had on information flow to help monitor and progress some of our indicators this year.

In setting our final quality priorities for 2014/15, we have actively involved, consulted and taken account of the views from key stakeholders including senior managers, i.e. (Corporate Management Team, Executive Committee), a range of clinical professionals, i.e. (Clinical Governance Steering Group and from patient and public representatives), i.e. (Council of Governors). In addition we have shared and refined our priorities through the Trust Annual Planning process.

Each of the quality priorities for 2014/15 and proposed indicators for improvement are described in detail below including how each will be measured, monitored and reported.

Patient Safety	*The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improve the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by conducting thorough investigation and analysis when things go wrong, identifying and sharing learning and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident and will strive to eliminate avoidable deaths as a consequence of care we have provided. We will also work to understand and improve our safety culture and to successfully implement proactive patient safety improvement programmes.*

Priority 1: - Treating and caring for patients in a safe environment and promoting 'harm free' care

Patient safety is a top priority at City Hospitals and our aim is to make patients and their families feel safe whilst in our care. The notion of 'harm free' care has arisen from a number of national quality improvement initiatives and the NHS Safety Thermometer is the latest programme for promoting patient safety improvement. It allows teams to measure harm and the proportion of patients that are 'harm free' during their working day, for example at shift handover or during ward rounds, and provides a 'temperature check' on harm which can be used alongside other local measures.

Why we chose this priority?

The concept of reducing avoidable harm arises from a growing body of evidence concerning certain complications which can, and should, be avoidable. It is nationally recognised that the achievement of 'harm free' care requires continuous effort from the healthcare team and we know we still have work to do in some key areas.

We have included some priorities from last year which are part of the NHS Safety Thermometer programme, such as reducing hospital acquired pressure ulcers and patient falls that cause serious injury. Despite a number of initiatives already implemented or being developed to mitigate these harms, we believe we still need to improve even further these areas in 2014/15.

Medication errors are one of the top categories of reported incidents nationally. During 2013/14 we wanted to develop systems that would help us monitor and reduce the frequency of occurrence using the enhanced functionality of the new V6 Meditech system linked to our Safeguard Incident Reporting System. Unfortunately, we were unable to develop the interaction between the two systems during the year to provide valid and reliable information. Given that the 'bedding in' period of the new system is now complete we feel we are now ready and able to develop this priority for 2014/15.

Venous thromboembolism (VTE) or blood clots, are a major risk to hospitalised patients. VTE can lead to pain, swelling and potentially to death as well as possible reputational and litigation risks for hospitals. Whilst the full scale of the problem is not known, it is estimated that hospital-associated VTE leads to about 40,000 deaths in England per year, 25,000 of which may be preventable through proper risk management and care. A number of interventions can reduce the risk of a patient suffering VTE while in hospital, and appropriate preventive measures can significantly reduce, but not eliminate, deaths from VTE. From a review of some of our reported incidents we need to ensure that suitable patients have a VTE risk assessment and "at risk" individuals are given appropriate treatment and preventive measures.

How will the priorities be measured, monitored and reported?

The table below sets out how our priorities will be measured, monitored and reported during 2014/15. For each clinical priority a group has been given responsibility to oversee the development of key actions and setting relevant targets to drive improvements. They will provide an important mechanism for regular monitoring, review and reporting to key named governance groups. A summary of progress of performance in each priority will be presented to Governance Committee, which is the formal sub-committee of the Board of Directors.

	Patient safety - Indicator	Measured by	Monitored by	Reported to
1	Reduce the number and severity of hospital acquired pressure ulcers	NHS Safety Thermometer	Patient Safety and Risk Management Team	Clinical Governance Steering Group
2	Reduce the number of drug errors which cause harm	Internal incident reporting system	Patient Safety & Risk Management Team	Clinical Governance Steering Group
3	Increase the reporting of incidents and 'no harm' events by staff	Internal incident reporting system	Patient Safety and Risk Management Team	Clinical Governance Steering Group
4	Reduce the number of serious patient falls, including those that result in fractured neck of femur	Internal incident reporting system	Falls Group	Clinical Governance Steering Group
5	Maintain the target of 95% of all adult inpatients having a VTE risk assessment on admission to hospital. Reduce the number of avoidable (preventable) VTE.	Internal measures	VTE Committee	Clinical Governance Steering Group

Clinical effectiveness	*We will ensure that each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.*

Priority 2: - Enhance the quality of life of patients with long term conditions - improve the in-hospital management of patients with Dementia

Dementia is one of the most important issues we face as the population ages. Up to 70% of acute hospital beds are occupied by older people, approximately 40% of whom have dementia. However, patients who have dementia experience many more complications and stay longer in hospital than those without dementia. It is also estimated that 30% of people will die with dementia and many of these die in general hospital settings. Improving the quality of care in general hospitals has been identified as a priority within the National Dementia Strategy.

Why we chose this priority?

The national audit of dementia care (2013) identified continuing problems in the quality of care received by people with dementia in hospitals in England and Wales. Although there has been some positive change, the audit showed that many patients are not receiving key health assessments. It also revealed that many hospitals do not provide dementia awareness training to new staff.

City Hospitals participated in the second round of the National Dementia Audit (first round was conducted in 2011) and we improved on many of the standards first audited in 2011. We are determined to continue the excellent work that has already taken place in order to enhance the hospital experience of this vulnerable group of patients. We have now developed our Dementia and Delirium Outreach Team to

champion the specific care needs of dementia patients and their carers and have established a dedicated Dementia Ward to foster the most appropriate dementia-friendly hospital environment.

We also need to continue to develop a workforce which understands dementia and which is equipped to respond appropriately to the needs of people with dementia in its care.

How will the priorities be measured, monitored and reported?

The table below sets out how our priorities will be measured, monitored and reported during 2014/15. For each clinical priority a group has been given responsibility to oversee the development of key actions and setting of relevant targets to drive improvements. They will provide an important mechanism for regular monitoring, review and reporting to key named governance groups. A summary of progress of performance in each priority will be presented to Governance Committee, which is the formal sub-committee of the Board of Directors.

	Clinical effectiveness - Indicator	Measured by	Monitored by	Reported to
1	Patients assessed as 'at-risk' of dementia will have diagnostic assessments, investigations and appropriate follow-up	CQUIN internal data collection	Performance Team Dementia Strategy Group	Clinical Governance Steering Group
2	Dementia patients to be assessed on their risk of developing malnutrition and dehydration on admission (MUST score)	Internal data collection	Nutrition Steering Group	Clinical Governance Steering Group
3	Appropriate training of staff who care for patients with dementia	Internal data collection	Dementia Strategy Group	Patient, Carer and Public Experience Committee
4	Ensure that carers of people with dementia feel supported	Carers Survey (as part of CQUIN)	Clinical Governance	Patient, Carer and Public Experience Committee
5	Improve the hospital environment for patients with dementia	Internal data collection	Dementia Strategy Group	Patient, Carer and Public Experience Committee

Patient Experience

We want all our patients to have a positive experience of healthcare. Patients and the people who care for them are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support. Our staff should be afforded the same dignity and respect by patients and by their colleagues. Our commitment to respecting everyone and working together is enshrined in the Trust's values. Through our core patient surveys, we have a strong understanding of the things that matter most to our patients; these priorities continue to guide our choice of quality objectives.

Priority 3: - Ensure that we give compassionate care and that people have a positive hospital experience

For patients in hospital, every detail of each interaction shapes the unique quality of their experience. From listening to patients, it is apparent that their experience of the hospital and hospital staff is shaped to a large degree by the actions, attitudes and behaviours of individual members of staff.

Going into hospital can be stressful and worrying. At City Hospitals we strive to make sure that patients have a positive experience during their stay. It is important to us that patients feel guided, supported and

respected throughout their admission. We know that often the smallest things can make the biggest difference, and we constantly review what we do to see where we can make things better.

Why we chose this priority?

The recent report on the Mid Staffordshire NHS Foundation Trust ('Francis Inquiry') provided a sobering account of where compassion in care was missing in day to day contact with patients and their families. Whilst in general our patients are telling us that we get it right most of the time, there are occasions when our doctors, nurses, and other healthcare staff have not shown enough compassion in their relationships with patients and their families. We know that compassion is central to how people perceive their care and how they describe their experience to others. The launch of our Compassionate Care – Customer Care Strategy in 2014 will demonstrate our ambition to refocus and reclaim compassion in care. Our continued participation in the Friends and Family Test and national patient surveys will provide a useful barometer as to whether compassion in care is being felt by patients and their families or whether it is being compromised.

The latest results from the National Adult Inpatient Survey show encouraging signs that we are getting better with managing patients' pain and giving patients choice in their meals. However, there can be no relaxation with these priorities until we are confident that progress and improvement is embedded across all our wards.

During 2014/15 we will ensure that the Trust responds to developments within the area of Duty of Candour obligations to further enhance our approach to openness and transparency with patients and their families.

How will the priorities be measured, monitored and reported?

The table below sets out how our priorities will be measured monitored and reported during 2014/15. For each clinical priority a group has been given responsibility to oversee the development of key actions and setting relevant targets to drive improvements. They will provide an important mechanism for regular monitoring, review and reporting to key named governance groups. A summary of progress of performance in each priority will be presented to Governance Committee, which is the formal sub-committee of the Board of Directors.

	Patient experience - Indicator	Measured by	Monitored by	Reported to
1	Improve the likelihood that patients would recommend our services to their family and friends	Friends & Family Test – 'net promoter score'	Patient, Carer and Public Experience Committee	Patient, Carer and Public Experience Committee
2	Increase the proportion of patients who feel listened to and involved in their care	National Inpatient Survey Real time feedback	Patient, Carer and Public Experience Committee	Patient, Carer and Public Experience Committee
3	Enhance the patients perception of pain management	National Inpatient Survey Real time feedback	Pain Management Group	Patient, Carer and Public Experience Committee
4	Increase the proportion of patients who report that they were given a choice of food	National Inpatient Survey Real time feedback	Nutrition Steering Group	Patient, Carer and Public Experience Committee
5	Training of staff in compassionate care	Internal data collection	Patient, Carer and Public Experience Committee	Patient, Carer and Public Experience Committee
6	Ensure consistency in the implementation of Duty of Candour	Internal data collection	Patient Safety & Risk Management Team	Clinical Governance Steering Group
7	Improve end of life care through implementation of the 'Deciding Right' regional framework	Audit of practice	End of Life Steering Group	Patient, Carer and Public Experience Committee

Staff Experience	*Staff who feel engaged, involved and valued provide a strong workforce and a strong workforce is essential to the achievement of continuous improvement in delivering healthcare services*

Priority 4: - Staff experience and promoting an open culture for delivering safe and compassionate care

Following the publication of the Francis Report (Mid Staffordshire), Trusts were reminded that they needed to listen better to patients and their relatives and act upon their experiences and complaints. However, it is imperative that they also listen to the experiences of staff. Mid Staffordshire showed that staff dissatisfaction can act as an early warning sign for when things are (potentially) going wrong and individual stories and comments from staff can be used to drive change.

Why we chose this priority?

We acknowledge that listening to the experiences of staff is just as important as listening to patients and their relatives if we want to improve the hospital experience for patients.

From 1st April 2014, all Trusts in England will be required to implement the Friends and Family Test for NHS staff on a quarterly basis. This has been driven by evidence which indicates an association between positively engaged staff and positive patient experiences. Research has also shown a strong relationship between staff engagement and patient satisfaction, patient mortality, infection rates and staff absenteeism and turnover.

One of the key actions from the national Compassionate Care Strategy is for organisations to become more transparent and consistent in publishing safety, effectiveness and experience data with the overall aim of driving improvements in practice and culture. The Open and Honest Care (Driving Improvement) programme aims to publish 'Open and Honest' reports and information for the public on areas such as falls and pressure ulcers, information on healthcare associated infection, staff experience and staffing levels. There will also be commentary describing the improvements being made to patient care. Reports and 'public-facing' information boards at ward level will be refreshed on a monthly basis.

How will the priorities be measured, monitored and reported?

The table below sets out how our priorities will be measured monitored and reported during 2014/15. For each clinical priority a group has been given responsibility to oversee the development of key actions and setting relevant targets to drive improvements. They will provide an important mechanism for regular monitoring, review and reporting to key named governance groups. A summary of progress of performance in each priority will be presented to Governance Committee, which is the formal sub-committee of the Board of Directors.

	Patient experience - Indicator	Measured by	Monitored by	Reported to
1	Improve the likelihood that staff would recommend the hospital to their family and friends	Staff Friends & Family Test scores	Patient, Carer and Public Experience Committee	Patient, Carer and Public Experience Committee
2	Ensure the appropriate number of Registered Nurses and Health Care Assistants on duty	Open & Honest programme	Nursing & Quality	Governance Committee
3	Implement the 'Open & Honest' Care programme as a mechanism for improving information about quality and safety for the public	Progress against action plan	Nursing & Quality	Governance Committee

Part 2.2 Statements of assurance from the Board of Directors

Review of services

During 2013/14 City Hospitals Sunderland provided and/ or sub-contracted 40 relevant health services.

City Hospitals Sunderland has reviewed all the data available to them on the quality of care in 40 of these relevant health services.

The income generated by the relevant services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by City Hospitals Sunderland for 2013/14. The data reviewed aims to cover the three dimensions of quality i.e. patient safety, clinical effectiveness and patient experience.

The Trust routinely analyses organisational performance on key quality indicators, benchmarked against national comparisons, leading to the identification of priorities for quality improvement.

The Board of Directors and the Executive Committee review the Service Report and dashboards monthly. There is a Quality Risk and Assurance Report presented monthly to the Board of Directors from the Governance Committee to provide further assurance from external sources such as the Care Quality Commission's Intelligent Monitoring Report, nationally reported mortality and outcome data, information from our quality provider (CHKS), the results of national audits and external inspections, the Trust Assurance Programme and local data such as the Friends and Family Test etc. The Governance Committee therefore provides assurance upon the adequacy and effectiveness of risk management and integrated governance within the organisation.

Participation in Clinical Audit and the National Confidential Enquiries

All NHS Trusts are audited on the standards of care that they deliver and our Trust participates in all mandatory national audits and national confidential enquiries. The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected data during 2013/14 (http://www.hqip.org.uk/national-clinical-audits-for-inclusion-in-quality-accounts/#2013)

During 2013/14, 36 national clinical audits and 4 national confidential enquiries covered relevant health services that City Hospitals Sunderland provide.

During that period City Hospitals Sunderland participated in 97% 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 was eligible to participate in during 2013/14 are as follows: (see table below).

The national clinical audits and national confidential enquiries that City Hospitals Sunderland participated in during 2013/14 are as follows: (see table below).

The national clinical audits and national confidential enquiries that City Hospitals Sunderland participated in, and for which data collection was completed during 2013/14, 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 2013/14

National Clinical Audits	Eligible	Participation	Comment
Older People			
Falls and Fragility Fractures Audit	√	√	Organisational and 40 cases submitted 100% compliance with study criteria
National Hip Fracture Database)	√	√	Continuous data collection
Sentinel Stroke National Audit programme (SSNAP), includes SINAP	√	√	Continuous data collection
Women and Children's Health			
Neonatal intensive and special care (NNAP)	√	√	Continuous data collection
Epilepsy 12 audit (Childhood Epilepsy)	√	√	Compliant with study criteria
Paediatric asthma	√	√	Compliant with study criteria
Paediatric intensive care (PICANeT)	N/A	N/A	
Acute Care			
Adult critical care (Case Mix Programme)	√	√	Continuous data collection
Emergency use of oxygen	√	√	Compliant with study criteria
Moderate or severe asthma in children (care provided in emergency department)	√	√	50 cases submitted 100% compliance with study criteria
National Audit of Seizure Management (NASH)	√	√	30 cases submitted 100% compliant with study criteria
National Emergency Laparotomy Audit	√	√	Continuous data collection
National Joint Registry	√	√	Continuous data collection
Paracetamol Overdose (care provided in emergency departments)	√	√	50 cases submitted 100% compliance with study criteria
Severe sepsis & septic shock	√	√	50 cases submitted 100% compliance with study criteria
Severe Trauma (Trauma Audit & Research Network)	√	√	Continuous data collection
Cancer			
Bowel cancer (NBOCAP)	√	√	Continuous data collection
Head and neck cancer (DAHNO)	√	√	Continuous data collection
Lung Cancer (NLCA)	√	√	Continuous data collection
Oesophago-gastric cancer (NAOGC)	√	√	Continuous data collection
Long term conditions			
Bronchiectasis (Paediatrics)	√	√	Shared care arrangement with Newcastle
National Chronic Obstructive Pulmonary Disease Audit Programme	√	√	Compliant with study criteria
National Diabetes (Adult)	√	√	Continuous data collection
National Diabetes Inpatient Audit	√	√	Compliant with study criteria Organisational and 96 cases submitted
Diabetes (Paediatric)	√	√	Continuous data collection

National Clinical Audits	Eligible	Participation	Comment
Inflammatory Bowel Disease	√	√	Compliant with 3 of the 4 elements to the study ie Organisational, patient care data and patient survey
Rheumatoid and early inflammatory arthritis	√	√	Compliant with study criteria
Heart			
Acute coronary syndrome or acute myocardial infarction (MINAP)	√	√	Continuous data collection
Adult cardiac surgery audit	N/A	N/A	
Cardiac arrhythmia management	√	√	Continuous data collection
Congenital heart surgery (paediatric cardiac surgery)	N/A	N/A	
Coronary angioplasty	√	√	Continuous data collection
Heart failure	√	√	Continuous data collection
National Vascular Registry	√	√	Continuous data collection
National cardiac arrest audit	√	√	Continuous data collection
Pulmonary hypertension	N/A	N/A	
Mental health			
National audit of schizophrenia	N/A	N/A	
Prescribing observatory for Mental Health	N/A	N/A	
Blood and transplant			
Management of patients in Neurological Critical Care Units	N/A	N/A	
Audit of information and consent	√	x	Partial compliance with study criteria
Audit of the use of Anti D (blood product)	√	√	Compliant with study criteria
Renal replacement therapy (Renal Registry)	√	√	Continuous data collection
Other			
Elective surgery (National Patient Reported Outcome Programme)	√	√	Continuous data collection

Source: Quality Accounts Resource 2010-15 (Healthcare Quality Improvement Partnership)

Clinical Outcome Review Programme

The Clinical Outcome Review Programmes (previously known as confidential enquiries), are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling clinicians, managers and policy makers to support changes that can help improve the quality and safety of patient care. The review programmes includes the following:

Enquiry title	Organisation	Acronym
Child health programme	Royal College of Paediatrics and Child Health (RCPCH)	CHR-UK
Maternal, infant and newborn clinical outcome review programme	National Perinatal Epidemiology Unit, Department of Public Health	MBRRACE-UK
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	NCEPOD
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), Centre for Suicide Prevention	NCISH

National Confidential Enquiries 2013/14

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 2013/14 City Hospitals was eligible to enter data into 4 NCEPOD studies. The tables below provide a summary of our participation.

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

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

Subarachnoid haemorrhage (SAH) – is a sudden leak of blood over the surface of the brain. The brain is covered by layers of membranes, one of which is called the arachnoid. A SAH occurs beneath this membrane.

Secondary Q. requested	Secondary Q. returned	Tertiary Q. requested	Tertiary Q. returned	Secondary CN returned	Tertiary CN returned	Sites participating	Organisational questionnaire returned
5	5	0	0	5	0	1	1

Tracheostomy Care – surgical procedure where the surgeon creates an opening in the neck at the front of the windpipe

Included Cases	Insertion Q. returned	Crit. Care Q. returned	Ward Care Q. returned	Cases notes requested	Case notes returned	Sites participating	Organisational questionnaire returned
11	11	10	8	2	2	1	1

Lower Limb Amputation*

Cases included	Clinical questionnaire returned	Case notes returned	Sites participating	Organisational questionnaire returned
7	7	7	1	1

* (Please note this study is still open and the figures have not been finalised)

Confidential Maternal and Child Health Enquiries (CMACE)

The Trust provides information to these national enquiries for all maternal, perinatal (the period shortly before and after birth) and child deaths through the Regional Maternity Survey Office (RMSO) and the North East Public Health Observatory (NEPHO). Participation in this audit provides useful benchmarking data across the North East.

MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths. The aims of MBRRACE-UK are to provide robust information to support the delivery of safe, equitable, high quality, patient-centered maternal, newborn and infant health services.

The maternity, neonatal and paediatric teams will continue to provide information relating to all child deaths from birth to 18 years of age to the RMSO office and the Child Death Overview Panels both of which review all child deaths on behalf of the Local Safeguarding Children's Boards. This allows for a multidisciplinary review of data and analysis for any trends and shared learning relating to these deaths. The Trust also provides details to the North East Public Health Observatory (NEPHO) to help collate data including diagnosis and incidences of congenital abnormalities; management and outcome data from multiple pregnancies; and diabetes in pregnancy. This data is analysed regionally and included in national analysis.

National clinical audits

The reports of 16 national clinical audits were reviewed by the provider in 2013/14 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

Audit title	Good outcomes / Actions taken
National Diabetes Inpatient Audit	The development of a dedicated Multi disciplinary Foot Protection Team has increased the level of foot screening, detection of the 'at risk' foot, and rapid treatment of acute foot ulceration in our patients. This has led to a significant reduction (above national average) in major amputation rates for patients with diabetes.
National Audit of Dementia (care in general hospitals)	A dementia clinical pathway has been developed by the Delirium Dementia Outreach Team (DDOT). DDOT provide in house education and training for staff to help them develop the knowledge, skills and confidence to care for people with dementia. The Trust has introduced a system of 'butterfly symbols' which are placed above the patient's bed to alert staff to the presence of dementia or memory impairment. The Trust has also adopted "This is me" as a tool for gathering information from carers about a person with dementia.
National Oesophago-Gastric Cancer Audit	Results show local investigation, treatment and onward referral to the regional centre are in line with national expectations.
UK Carotid Endarterectomy Audit	Improvement from Round 3 to Round 4 on all but one of the outcomes, with a significant improvement for patients having surgery within 14 days of their symptoms. This is higher than the national average. This significant improvement has been achieved through improved teamwork with stroke physician colleagues.
National Heart Failure Audit	Monitors the care and treatment of patients admitted with heart failure. There have been several improvements over the audit period, including; • the percentage of admitted heart failure patients managed primarily by a Cardiologist has increased with almost all patients having cardiologist involvement in their care; • an improvement in the rate of follow up in the cardiology outpatient clinics; • increase in the rate of echocardiography during the initial hospital stay; • the number of patients considered for beta blocker therapy has increased; • improvement in the rate of referral to the community heart failure service; and • a fall in the 30 day readmission rates. A case study vignette highlighting these improvements was published as a 'best practice example' in the national Audit Report 2012/13.
National Hip Fracture Database	The Trust has a better compliance rate with the best practice tariff (BPT) than local peers. The BPT offers additional payment for cases which meet national agreed quality standards, for example surgery within 36 hours, shared care by surgeon and care of the elderly clinicians, cognitive function assessment, multi-disciplinary rehabilitation and secondary falls prevention. Work is ongoing to improve the clinical pathway and establish closer relationships with Elderly Medicine.

Local clinical audit

The reports of 163 local clinical audits were reviewed by the provider in 2013/14 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

Audit title	Good outcomes / Actions taken
X-raying hips in recovery	The outcomes of the audit show an improvement in the speed of patients through recovery with no additional risks to patient safety.
Trauma & Orthopaedic theatre record - keeping	An aide memoire has been developed to improve documentation and accountability.
Dupuytren's Contracture (thickening of the fibrous tissue layer underneath the skin of the palm and fingers)	Audit has resulted in a number of developments for the hand service. For example, collagenase injections, giving outpatient treatment with good early results, and thereby avoiding the need for surgery and lengthy rehabilitation.
Bariatric patients (postoperative blood testing)	Introduction of a 'bariatric admission set' (essential blood tests and checks) which has led to improvements in the preoperative and postoperative care of bariatric patients.
Quality of clerking of acute surgical patients	Developed proforma for clerking of acute surgical patients.
First afebrile seizure (without a fever) in children and young people	Following the audit an information leaflet was developed to raise awareness for this group of patients.
Children's Diabetes	The audit contributed to a new policy and process for the management of diabetes that has now been put in place.
Documentation audit Neonatal Unit	Introduction of a revised clerking proforma for admissions following the audit.
Ambulatory care pathway clinic in diabetes	Demonstrated an improvement in glycaemia (blood sugar) control, admission prevention and achievement of early discharge in this group of patients.
Hyponatraemia (low sodium levels in the blood) management in inpatients looking at non ICCU/Renal moderate-severe hyponatraemia	Audit has resulted in the recommendation of focused hyponatraemia teaching in junior doctor induction and a junior doctor handbook.
Audit of ICCU pressure ulcer prevalence	Implemented enhanced preventive measures, reducing pressure ulcer incidents by 76% from the previous 12 month period and eradicating hospital acquired category 3 and 4 ulcers.

Participation in clinical research

City Hospitals Sunderland is committed to providing quality healthcare by ensuring world class clinical services are seamlessly integrated with research and innovation in line with the Department of Health's 'Improving the Health and Wealth of the Nation' agenda. The organisation has demonstrated success in delivering the National Institute for Health Research (NIHR) Portfolio, and presented a vision to the Trust Board in August 2013 which outlined how the Research & Development department will address the innovation programme in parallel with the NIHR portfolio. To achieve this, the department will work collaboratively with the Academic Health Science Network to enable timely dissemination of research findings and translation into clinical care. In future the Research and Development department will be known as Research and Innovation.

Research and Innovation will work toward the NIHR Higher Level Objectives of:

- increasing the proportion of NIHR Portfolio studies that are delivered in line with the studies' planned delivery times and patient recruitment targets;
- doubling the number of participants recruited into studies on the NIHR Portfolio;
- reducing the time it takes to get NHS permission for a study to start;
- reducing the length of time it takes to recruit the first participant onto NIHR Portfolio studies; and
- increasing the number of life-sciences studies on our NIHR Portfolio.

Increasing research activity and recruitment

The number of patients receiving relevant health services provided or sub-contracted by City Hospitals in 2013/14 who were recruited during that period to participate in research approved by a Research Ethics Committee was 1,587 and this exceeds the target recruitment of 1321 for 2013/14.

There are currently 268 research studies approved by the Health Research Authority (National Research Ethics Committee) registered at City Hospitals Sunderland, an increase of 26 from 2012/13. We have been able to meet the NIHR objective of approving 80% of studies within 30 days.

Sunderland Eye Infirmary has been recognised for its research achievements, particularly pertaining to industry studies. It is within the top three for recruitment in the UK for three of the studies it has been involved in and has exceeded the target in one other study. The Obstetrics and Gynaecology and Urology teams were the first in Europe to recruit into a commercial study, receiving national recognition. This was made possible by an innovative cross-specialty approach, working together on the same study.

The Cardiology team have increased recruitment exponentially, exceeding targets by 50%. City Hospitals has a well balanced portfolio across specialties, with research in new clinical areas. The specialty of Ears, Nose and Throat has for example offered patients the opportunity to participate in studies using the latest techniques, devices and medical treatments. Likewise the Trust has been keen to support multi-disciplinary work exploring health service research and patient experience.

The Trust has a strong research culture and has initiated a number of multi-disciplinary research seminars and training programmes throughout the year.

Information on the use of the CQUIN framework

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

A proportion of City Hospitals Sunderland's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between City Hospitals Sunderland and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically www.chsft.nhs.uk.

For 2013/14, approximately £6.69m of income (£6.45m in 2012/13) was conditional upon achieving quality improvement and innovation goals through the CQUIN framework. The Trust achieved the majority of these quality goals and has received a monetary total of £6.69m (100%) (£6.39m in 2012/13) for the associated payment in 2013/14, reflecting actual performance and action plans to work towards achievement of full implementation.

The full CQUIN scheme 2013/14 and where we have achieved our targets are highlighted below:

No	Description of Goal	Indicator	Priority	Achievement*
1a	Patient Experience	Friends and family test - phased expansion	National	
1b		Friends and family test - increased response rate		
1c		Friends and family test - improved performance on the staff friends and family test		
1d		i) share a forward plan of patient experience work for 13/14		

		ii) plan to include real time feedback and CCG presence on patient experience visits as well as other methods across a range of services		
		iii) each quarter demonstrate where improvement have been made as a result of feedback from patients		
1e		Acute paediatrics - patient experience collected, reviewed and improvements made based on feedback		
2a	NHS Safety Thermometer	NHS Safety Thermometer - data collection	National	
2b		NHS Safety Thermometer - improvement. Reduction in the prevalence of pressure ulcers (New))		
3a	Dementia - Find, Assess, Investigate and Refer	i) % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question		
		ii) % of all patients aged 75 and over, who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool	National	
		iii) % of all patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis		
3b		Dementia - Clinical Leadership	Local	
3c		Dementia - Supporting Carers of People with Dementia	Local	
3d		implementation of an improvement plan linked to organisational dementia strategy	Local	
4a	Thromboembolism (VTE)	VTE risk assessment - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	National	
4b		VTE root cause analyses- number of root cause analyses carried out on cases of hospital associated thrombosis	Local	
5	Emergency Department	i) Implementation of a collaborative improvement plan with NEAS - link to implementation of recommendations from the RPIW held in March 2013	Local	
		ii) Implementation of ECIST recommendations		
6a	Communication	Communication - outpatient clinic letters issued	Local	
6b		Collaborative discharge planning		
6c		i) Implementation of discharge communication improvement plan		
		ii) increase % of summaries issued within 24 hours (goal TBC) (specific target for acute paediatrics 2013/14)		
		iii) improve quality of content		
		iv) progression toward electronic transfer of summaries		
6d		Communication of results		
7a	Appointments	implementation on an improvement plan over 2012/13 and 2013/14 to: i) reduce DNA rates	Local	
7b		ii) reduce the number of cancellations		
7c		iii) improve the timeliness of review appointments		
8a	Long term conditions	percentage of inpatients with a primary diagnosis of heart failure receiving all 7 indicators from the heart failure bundle	Local	

8b		i) COPD - proportion of patients receiving all elements of discharge bundle		
		ii) COPD - proportion of patients seen by Thoracic Medicine consultant/COPD Specialist Nurse		
8c		Diabetes - identify cluster of indicators linked to NICE		
		i) % of patients aged > 19 and with Type 1 Diabetes with 9 Key Processes within 12 month		
		ii) % diabetes patients with HbA1c Test		
		iii) % of patients aged >19 with known diabetes with a foot care assessment		
8d		Parkinson's Disease i) To ensure all patients diagnosed with Parkinson's disease are reviewed in a combined clinic		
		ii) To ensure all patients diagnosed with Parkinson's disease who ring the Nurse Specialist receive a response within 1 working day		
		iii) To increase admissions seen by the (PD team) within 1 working day		
8e		Review best practice for paediatric asthma and spread and share; i.e. access, paediatric asthma nurse work		
9a	Falls	Capture of falls information in A&E	Local	
		i) Number of patients over 65 attending A&E as a result of a fall who have had 2 or more falls in the previous 12 months who have been referred		
		ii) Number of patients over 65 attending A&E as a result of a fall who have had 2 or more blackouts in the previous 12 months who have been referred		
		iii) Number of patients over 65 attending A&E as a result of a fall who have sustained a fracture on this presentation and referred		
		Number of fallers aged 65 and over referred from A&E in whom an initial assessment has been completed within 4 weeks of receipt of referral.		
		Evidence of timely and appropriate assessment by falls services including initial falls assessment and screening for osteoporosis		
9b		Percentage of patients 65 and over admitted to hospital as an emergency to have all 9 indicators within the falls bundle within 24 hours of admission		
10a	Health Improvement – Alcohol	Proportion of patients attending A&E who have alcohol status recorded	Local	
10b		Proportion of those patients reporting higher levels of alcohol who have received a brief intervention		
11a	End of Life	Deciding right - % of clinical staff trained in the contents and principles of 'Deciding Right' and use of new standard documentation	Local	
12a	Learning disabilities	Compliance with regional learning disabilities pathways	Local	
13a	Medicines Management	Dietetics - enteral nutrition	Local	
13b		Total number of suspected Neutropenic sepsis patients entered on the patient pathway and receive antibiotics within 1 hour of being diagnosed		

14a	Trauma and Orthopaedics	Improvement in Oxford Hip– Case mix adjusted health gain, as defined by PROMs documentation		
14b		Improvement in Oxford Knee Score – Case mix adjusted health gain, as defined by PROMs documentation	Local	
14c		Patients with hip fracture –Mortality		
14b		Patients with hip fracture aged 70 or over - return to theatre for a hip or wound related procedure within 30 days of the index operation		
14e		a) Revision of hip replacement within 1 year of the primary joint replacement		
		b) Revision of knee replacement within 1 year of the primary joint replacement		
14f		Increase the proportion of cemented replacements performed in patients over 65		
14g		Implementation of shared decision making tool in hip/knee pathway		
15a	Mental Health in pregnancy	To implement assessment for depression in pregnancy and ensure referral to other services/ notification to GP is actioned	Local	
16a	Right Test First Time	Develop recommendations for the 'Right test First Time' to include Pathology & Radiology referrals	Local	

Key

Full achievement

Partial achievement or further work on-going

Not achieved

* Based on indicative position to be agreed with Sunderland Clinical Commissioning Group.

Information relating to registration with the Care Quality Commission

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

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

The Care Quality Commission has not taken enforcement action against City Hospitals Sunderland NHS Foundation Trust during 2013/14.

City Hospitals Sunderland has not has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Care Quality Commission – Inspection Report (January 2014)

The Care Quality Commission carried out a routine unannounced inspection to check that essential standards of quality and safety were being met. The inspection took place on the 10th and 11th of December 2013 and focused on the accident and emergency department, care of the elderly ward areas and outpatients. The inspection also focused on human resources processes, complaints processes, governance and risk.

As part of the process, the inspection team looked at the personal care or treatment records of people who use the service, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. The inspectors also spoke with people who use the service, with carers and / or family members and talked with hospital staff. They also reviewed information given to them by the Trust, information provided by local groups of people in the community or voluntary sector and information sent to them by commissioners of services and from other regulators.

In their report the CQC stated that City Hospitals was meeting **all the essential standards**; they found no concerns or requirement for further regulatory action or improvement plans. The judgement statements for each of the five standards reviewed are highlighted below.

Standards which were checked	Met this standard
Outcome 1 Respecting and involving people who use services	✓
Outcome 4 Care and welfare of people who use services	✓
Outcome 12 Requirements relating to workers	✓
Outcome 16 Assessing and monitoring the quality of service provision	✓
Outcome 17 Complaints	✓

The report was very positive with excellent patient responses and good reports on the environment and clinical care. Areas for improvement included quicker response times for complaints and environmental issues in some outpatient areas which may have an impact on patient privacy and dignity, for example shortage of seating and closing of doors during consultations.

The final report is available on the Care Quality Commission website.

Care Quality Commission Mortality Alert

In March 2014 City Hospitals received a mortality outlier review from the Care Quality Commission. Their analysis of mortality data showed a higher than average rate for pneumonia compared with peers. We have undertaken a retrospective case note review of a sample of patient deaths as suggested by the CQC. We found no evidence of any serious issues relating to the quality of clinical care and in all cases the deaths were viewed as not being preventable given the patient's condition and evidence of co-morbidities. However we did identify some areas where we needed to make some improvements, e.g. senior medical involvement in completing death certificates, coding of palliative care.

The Trust has submitted its detailed report to the Care Quality Commission and shared the findings with Commissioners.

Intelligent Monitoring Report (IMR)

During 2013, the Care Quality Commission published its new intelligent monitoring tool as part of radical changes to the way it inspects and regulates acute hospitals. Their strategy has been to move from a 'tick-box' approach to a more in-depth and joined-up approach to reviewing, registering and regulating health

and social care services. Together with information from local partners and the public, intelligent monitoring is designed to help the CQC to decide when, where and what to inspect.

The intelligent monitoring report replaces the previous Quality Risk Profiles and has around 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance. The indicators relate to the five key questions the CQC will ask of all services as to whether they are safe, caring, effective, well-led and responsive to people's needs. The indicators are used to inform questions about the quality of care, but not in isolation. Judgements will always be based on the result of an inspection, which will take into account the IMR alongside local information from the public, the Trust and other organisations. Using statistical tests to determine risk thresholds, the IMR identifies three possible ratings against each of the indicators– 'no evidence of risk', 'risks' and 'elevated risks'.

In October 2013, the CQC published the first IMR and grouped all acute NHS Trusts in England into six bands based on the risk that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest.

The first Intelligent Monitoring Report for City Hospitals identified three elevated risks and five risks, and placed the Trust in band 4 out of 6. We are disappointed to learn that the second IMR published in March 2014 shows a higher risk profile and a Band 2 rating. We are reviewing those areas highlighted as risk or elevated risk and focusing actions on mitigation where we can.

Quality of data

Good quality information underpins the effective delivery of patient care and helps staff to understand what they do well and where they might improve. The Board of Directors attend regular development sessions and seminars to ensure that every member of the Board is equipped to interpret data and challenge and oversee improvements where necessary. They consider the data provided with other intelligence including listening to what patients are saying. Our executive and non-executive directors undertake walkabouts in clinical areas talking to patients and staff about their experiences.

NHS Number and General Medical Practice Validity

City Hospitals Sunderland submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are then included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS number was:		Which included the patient's valid General Medical Practice Code was:	
Percentage for admitted patient care	99.9%	Percentage for admitted patient care	99.9%
Percentage for outpatient care	99.9%	Percentage for outpatient care	99.9%
Percentage for accident and emergency care	97.2%	Percentage for accident and emergency care	99.8%

Information Governance Toolkit

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

Annual ratings of green (pass) or red (fail) are assigned to Trusts each year. The final submission of the Toolkit had to be made by the 31 March 2014.

City Hospitals Sunderland's Information Governance Assessment Report overall score for 2013/14 was 86% (an increase of 2% from last year) and was graded Green (satisfactory). Church View Medical Centre's

(managed by City Hospitals Sunderland) submission for 2013/14 was 88%, maintaining last year's compliance figure, and is also graded Green (satisfactory).

The following table shows progress with ratings when compared to the previous 2 years.

Requirement	2011/12 rating	2012/13 rating	2013/14 rating	Comparison
Information governance management	86%	86%	100%	✓
Corporate Information Assurance	66%	77%	77%	⇔
Confidentiality and Data Protection assurance	75%	75%	75%	⇔
Secondary use assurance	91%	95%	95%	⇔
Information security assurance	82%	82%	82%	⇔
Clinical information assurance	93%	93%	93%	⇔
All initiatives	**83%**	**84%**	**86%**	✓

⇔ = same score

As in previous years, Sunderland Internal Audit Services (SIAS) has been engaged in the process and has audited the recommended toolkit submission for City Hospitals. Their report gave a rating of **significant assurance.**

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. The information is vital to the Trust as it supports;

- the delivery, planning and monitoring of patient care services,
- the planning and management of the Trust's services, and
- the collection of income

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

Sample tested (number)	% diagnosis incorrect		% procedures incorrect	
	Primary	Secondary	Primary	Secondary
Co-morbidities and complications in urological and male reproductive system procedures and disorders (100)	1.0	6.5	4.8	7.2
Co-morbidities and complications in Cardiology (100)	1.0	2.2	0.0	0.0

In the sample audited, the Trust had an overall error rate* of 1.1%. This means that 1.1% of spells (2 spells) had either a clinical coding error affecting the HRG, or a data entry error (or both). This performance would place the Trust in the best performing 25% compared to last year's national performance.
(*These figures contain all error types)

Based on the audit completed the auditors have made one recommendation to the Trust, the delivery of training sessions for coders with the emphasis on the identification and coding of co-morbidities. The Trust has already held a series of training sessions with coding staff on co-morbidity coding. Commissioners and the Trust will monitor delivery of the recommendation through routine contract monitoring meetings.

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.

Part 2.3 Reporting against core indicators

The Quality Report includes a set of mandatory core quality indicators which uses a standardised format to enable comparison of hospital performance. The indicators are linked to the NHS Outcomes Framework, which provides an overarching plan for delivering improvements and good clinical outcomes across the NHS, and are based on five 'domains of care'.

The indicators relevant to City Hospitals are shown below:

Outcome Framework domain	Indicator
Domain 1: Preventing people from dying prematurely	Summary hospital-level mortality indicator (SHMI) Palliative care coding
Domain 3: Helping people to recover from episodes of ill health or injury	Patient reported outcome measures (PROMS)
As above	Emergency readmissions to hospital within 28 days of discharge
Domain 4: Ensuring that people have a positive patient experience	Responsiveness to inpatients' personal needs
As above	Percentage of staff who would recommend the provider to friends or family needing care
Domain 5: Treating and caring for people in a safe environment and protecting then form avoidable harm	Percentage of admitted patients risk assessed for VTE
As above	Rate of *Clostridium difficile*
As above	Rate of patient safety incidents and percentage resulting in severe harm or death

Domain 1: Preventing people from dying prematurely
This is about reducing premature mortality from some of the major causes of death, for example, heart disease, chest disease, liver problems and cancer

Summary hospital-level mortality indicator (SHMI)

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

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

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

This indicator is divided into two parts;

- (a) SHMI values and banding
- (b) Percentage (%) of patients whose treatment included palliative care

(a) SHMI values and banding

Indicator	April 11-March 12	July 11-June 12	Oct 11-Sept 12	Jan 12-Dec 12	April 12 – March 13	July 12 – June 13	Oct 12 – Sept 13
City Hospital's SHMI	0.91	0.92	0.93	0.96	1.01	1.03	1.09
City Hospital's SHMI banding	Band 2	Band 2	Band 2	Band 2	Band 2	Band 2	Band 2
National average	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Highest SHMI value – national (*high is worse*)	1.24	1.25	1.21	1.19	1.16	1.15	1.18
Lowest SHMI value – national (*low is better*)	0.71	0.71	0.68	0.73	0.65	0.62	0.63

Data Source – Health & Social Care Information Centre

The most recent publication shows that City Hospitals has a Band 2 'as expected' mortality rating; the majority of NHS Trusts are banded at this level.

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

The coding of palliative care in a patient record has a potential impact on hospital mortality. The SHMI makes no adjustments for palliative care coding (unlike some other measures of mortality), so all patients who die are included, not just those expected to die.

Indicator	% of admissions with palliative care coding						
	April 11-Mar 12	July 11-June 12	Oct 11-Sept 12	Jan 12-Dec 12	April 12 – March 13	July 12 – June 13	Oct 12 – Sept 13
	0.8	0.8	0.8	0.7	0.7	0.7	0.8
National average	1.02	1.05	1.07	1.09	1.16	1.13	1.23
Highest national	3.3	3.3	3.2	3.0	3.1	3.2	3.1
Lowest national	0	0	0	0	0	0	0

Indicator	% of deaths with palliative care coding						
	April 11-Mar 12	July 11-June 12	Oct 11-Sept 12	Jan 12-Dec 12	April 12 – March 13	July 12 – June 13	Oct 12 – Sept 13
	13	11.9	11.5	10.7	11	10.8	11.2
National average	18.1	18.6	19.2	19.48	20.3	20.6	21.28
Highest national	44.2	46.3	43.3	42.7	44.0	44.1	44.9
Lowest national	0	0.3	0.2	0.1	0.1	0	0

Data Source – Health & Social Care Information Centre

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

- For all of the SHMI releases to date, mortality for the Trust has been described as being 'as expected' compared with other hospitals across the NHS and
- The Trust is proactive in monitoring mortality and in investigating and explaining variations in mortality performance.

City Hospitals Sunderland has taken / intends to take the following actions to improve the indicator and percentage in a) and b), and consequently the quality of its services, by:

- strengthening the role of the Trust-wide Mortality Review Group in the governance of corporate and local arrangements for reviewing deaths and optimising learning and improvement;

- developing a Trust wide mortality review panel to review all patient deaths, assessing whether there are avoidable and whether there exists any remedial clinical and / or organisational factors;
- ensuring that directorates and specialties undertake routine mortality/morbidity review meetings and implement changes in practice, where necessary;
- strengthening our internal systems for monitoring mortality and ensuring that any outlier performance or variation is properly investigated and reported;
- focusing upon specific conditions or procedures where mortality appears to be higher than expected; and
- improving aspects of clinical coding where intelligence suggests our performance is below peer performance, i.e. use of co-morbidities and Palliative Care coding.

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

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

Patient reported outcome measures (PROMS)

PROMS provide an important means of capturing the extent of the improvement in health following surgery or ill health as reported by patients. Trusts are required to report on relevant patient-reported outcome measures PROMs, which currently include four elective NHS procedures, hip or knee replacements, groin hernia surgery and varicose vein procedures.

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

PROMS measure (EQ-5D index) Patients reporting improvement following:	**2011/12 Adjusted average health gain**	**2012/13 Adjusted average health gain**	**2013/14* Adjusted average health gain**	**National average (2013/14)**	**Highest national**	**Lowest national**
Hip replacement	0.383	0.409	0.40	0.439	0.53	0.30
Knee replacement	0.307	0.319	0.294	0.330	0.42	0.19
Varicose vein procedures	0.070	0.094	0.070	0.101	0.16	0.02
Groin hernia procedures	0.081	0.084	0.055	0.086	0.16	0.01

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

* Reporting period covering April 13 – December 2013 (Latest publication release May 2014)

The EQ-5D Index is derived from a profile of responses to five questions about health 'today', covering activity, anxiety/depression, discomfort, mobility and self care. Weights had been applied to the responses to these questions to calculate the 'index'. All five questions have to be answered in order to do this. The higher the index the better the patient, with one (1) being the best possible score.

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

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

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

- sharing and reflecting on the results of our PROMS participation with key members of the clinical team;
- providing clinician-level data to enable comparison regarding case-mix by consultant, surgical procedure and patient demographics;
- reviewing the preoperative process to maximise patient participation in the PROMS programme; and
- raising awareness among staff on the benefits of PROMS information.

Emergency readmissions to hospital within 28 days of discharge

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

% of patients readmitted to hospital within 28 days of being discharged from hospital (Large acute or multi service)	0-15 years	16 and over
2013/14*	6.6	4.8
2012/13*	7.1	6.6
2011/12	9.29	12.93
National average	8.67	9.90
Highest national	14.94	13.8
Lowest national	0.00	0.00
2010/11	8.13	12.48
National average	8.62	9.85
Highest national	14.11	14.06
Lowest national	0.00	0.00
2009/10	7.67	12.08
National average	8.44	9.62
Highest national	15.35	13.18
Lowest national	0.00	0.00

Source – Health & Social Care Information Centre – emergency admissions to hospital with 28 days of discharge: indirectly standardised % < 16 years and >16 years annual trend (based on the latest available information)
* Internal data from City Hospitals Performance Department

City Hospitals Sunderland considers that this data is as described for the following reason: reducing avoidable readmissions remains a high priority for the Trust and the overall position for patients 0-15 years continues to be better than the national average although we acknowledge that further work needs to be done to improve readmissions for those aged 16 and over.

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

- continuing to report our re-admission performance to the Board of Directors and to discuss plans to reduce unnecessary re-admissions at quarterly performance reviews with directorates, and
- developing re-admission avoidance schemes which will include appropriate quality discharge arrangements as well as linking with community service providers to ensure appropriate onward care.

Domain 4: Ensuring that people have a positive patient experience
The views and experiences of patients and their interactions with our clinical and non-clinical staff matter. They can provide us with valuable information which we can use to drive improvements and create a better service.

Responsiveness to inpatients' personal needs

The measure is based on a composite score calculated on the average from five individual survey questions from the National Adult Inpatient Survey. The results are shown in the table below; the higher the score out of 100 the better the patient experience.

Composite score	2010/11	2011/12	2012/13	2013/14
City Hospitals Sunderland	68.3	71.4	68.9	64.4
National average	67.3	67.4	68.1	68.7
Highest national	82.6	85.0	84.4	84.2
Lowest national	56.7	56.5	57.4	54.4

Data source - National Adult Inpatient Survey 2013 (Care Quality Commission)

* This indicator forms part of the NHS Outcome Framework (Domain 4 - Indicator 4.2) - Health & Social Care Information Centre

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

- the results in 2013/14 show modest performance in the national survey overall and a further reduction in the composite score from previous years.

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

- continuing to improve nutritional care in hospital and the patient's overall mealtime experience;
- ensuring that staff respond swiftly and appropriately to patients' need for pain relief;
- monitoring patient feedback through real time feedback questionnaires and acting on results;
- reviewing the results of the 'Friends & Family Test' data in parallel with real time feedback information on a ward by ward basis;
- implementing the Trust Compassionate Care Strategy; and
- providing summary information about patient experience to the Patient, Carer and Public Experience Committee.

Percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends

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

Indicator	2010	2011	2012	2013	National average	Highest national	Lowest national
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust"*	57%	59%	63%	59%	67%	94%	40%

Source – NHS Staff Survey 2013 (Health & Social Care Information Centre)

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

Average score for each quartile	
1st quartile	52.057
2nd quartile	62.017
3rd quartile	70.569
4th quartile	83.781

Trusts in the 4th quartile are the top performers. City Hospitals score is in the 2nd quartile.

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

- The Trust has a strong culture of quality, improvement and patient safety and a consistent record of positive feedback in staff surveys, although our score in the latest survey is below the national average. We take a proactive role in taking action to improve areas highlighted by the survey.

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

- ensuring that quality and improvement are part of our strategic aims, vision and aspirations;
- focusing on developing staff leadership in key roles and implementing a range of strategies to improve staff morale and engagement as precursors to providing high quality care;
- ensuring that front line staff continue to influence and play an active part in the transformation and reform of our emergency care pathways and supporting services; and
- implementing the Staff Friends and Family Test and using the information to target local quality improvement.

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

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

Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)

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

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

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

% of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE)					
2011/12	2012/13	2013/14			
		Q1	Q2	Q3	Q4
92.1%	92.4%	95.20%	95.53%	95.14%	95.53%
		National average			
		95.42%	95.79%	95.71%	* Not available
		Highest national			
		100%	100%	100%	* Not available
		Lowest national			
		78.78%	81.7%	74.1%	* Not available

Data source - Health & Social Care Information Centre (H&SCIC)
* Information from the H&SCIC is not complete yet for Quarter 4 2013/14

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

- the whole VTE risk assessment pathway has been reviewed and revised to incorporate the requirements of national best practice guidance such as NICE and the recommendations of national bodies such as the All-Party Parliamentary Thrombosis Group; and
- the VTE Committee overseas the implementation of the VTE risk assessment pathway and regularly monitors ward compliance.

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

- making further enhancements to the current VTE pathway to ensure that it is able to meet a target of more than 95% of patients being risk-assessed;
- focusing on education and training programmes for all relevant staff including documentation of risk assessment; and
- reviewing the data from the NHS Safety Thermometer as a further driver to the achievement of high compliance rates.

Rate of *Clostridium difficile* infection

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

Rate per 100,000 bed days for specimens taken from patients aged 2 or over (Trust apportioned cases)					
	2009/10	2010/11	2011/12	2012/13	2013/14
City Hospitals	33.5%	19.4%	26.6%	25.2%	16.3%*
National average	35.3%	29.7%	22.2%	17.3%	Not available
Highest national	92.0%	71.2%	58.2%	30.8%	Not available
Lowest national	0.00%	0.00%	0.00%	0.00%	Not available

Source – Health & Social Care Information Centre
* Data provided by City Hospitals Performance Department

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

- The Trust has continued to work hard to reduce the numbers of C.*difficile* infection. This improving trend has continued into the current year as described later in the report.

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

- increasing analysis of antimicrobial prescribing for patients to prevent *Clostridium difficile* infection,
- extension of our surgical site surveillance programme across the organisation,
- distribution of *Clostridium difficile* infection patient held cards,
- in house provision of hydrogen peroxide for preventative deep cleaning,
- the introduction of an equipment replacement programme; and
- increasing the number of 'isolation' facilities.

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

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

This indicator has been subject to limited assurance from our external auditors as mandated by Monitor i.e. the reported figure for 2013/14. The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to below;

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

The table below shows the comparative reporting rate, per 100 admissions, for large acute NHS organisations. For the most recent reporting period (April – Sept 2013), City Hospitals reporting rate has remained stable at 8.7%. This significant progress reflects the success of a concerted programme of Trust activity and raising awareness among staff to promote higher rates of incident reporting.

	CHS reporting rate (%)*
1 Oct 2013 – 31 March 2014**	xx
1 April 2013 – 30 Sept 2013	8.7
National average	7.1
Highest national	11.1
Lowest national	3.9

1 Oct 2012 – 31 March 2013	8.7
1 April 2012 – 30 September 2012	5.1
1 October 2011 – 31 March 2012	4.3
1 April 2011 and 30 September 2011	5.0
1 October 2010 to 31 March 2011	5.4
1 April 2010 to 30 September 2010	5.2

Source – Organisation Patient Safety Incident Reports workbook (Large Acute) via Health & Social Care Information
* Incidents reported per 100 admissions
** data not available

The percentage of reported incidents relating to severe harm or death is now well above the national average. In addition the Trust's degree of harm profile remains distinctly different from the peer profile, mainly related to differences in the recording of fewer incidents with no harm and more incidents with low harm. The Patient Safety and Risk Team have been promoting incident reporting and the importance of identifying near miss events throughout the year.

Incidents reported by degree of	Severe harm	Death
1 Oct 2013 – 31 March 2014*	14 (0.23%)	3 (0.05%)
1 April 2013 – 30 Sept 2013	12 (0.2%)	1 (0.0%)
National average	0.5%	0.1%
Highest national	2.97%	0.31%
Lowest national	0.01%	0.0%
1 Oct 2012 – 31 March 2013	37(0.7%)	20 (0.4%)
1 April 2012 – 30 September 2012	28 (0.9%)	10 (0.3%)
1 October 2011 – 31 March 2012	21 (0.8%)	2 (0.1%)
1 April 2011 and 30 September 2011	33 (1.1%)	8 (0.3%)
1 October 2010 to 31 March 2011	57 (1.8%)	10 (0.3%)
1 April 2010 to 30 September 2010	47 (1.5%)	8 (0.3%)

Source – Organisation Patient Safety Incident Reports workbook (Large Acute) via Health & Social Care Information Centre
* National data not available, internal Trust data provided

Recently, the Trust approved the use of the term 'no harm' to replace 'near miss' reporting. The Patient Safety and Risk Team believe that this change in terminology will help increase the reporting of these types of incidents and from their analysis will mitigate and reduce more moderate and/or serious incidents.

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

- the Trust has a higher incident reporting rate than its national peer group and this potentially reflects a more safety conscious organisation; and
- we have traditionally had a culture of low reporting of incidents, in particular those categorised as 'near miss' or low degrees of harm.

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

- continuing to develop our programme of patient safety and quality initiatives, i.e. local campaign to 'Keep calm and carry on reporting incidents' and frequent 'Lessons learnt' seminars accessible to all staff,
- implementing recommendations and actions from the Trust-wide staff safety culture survey undertaken in 2013; and
- identifying staff groups with low incident reporting and targeting them to improve their reporting habits.

Part 3: Review of Quality Performance 2013/14

Part 3 provides an opportunity for the Trust to report on progress against additional quality indicators. We agreed to measure, monitor and report on a limited number of indicators selected by the Board in consultation with key stakeholders. Some of the indicators are more difficult to provide a strict measure of performance than others, but nonetheless they are important aspects of improving overall quality for patients. Often these types of indicators will highlight areas for further action for improvement. We have also decided to change some indicators from 2012/13 either because they are reported under the CQUIN scheme (end of life care, discharge communications), are already part of the Trust performance scorecard (reporting times for radiology) or they are part of existing reporting structures with our commissioners (Never Events).

In keeping with the format of the Quality Report, indicators will be presented under the heading of patient safety, clinical effectiveness and patient experience.

Later in this section, performance will be summarised against key national priorities.

Focusing on patient safety – "protecting you"

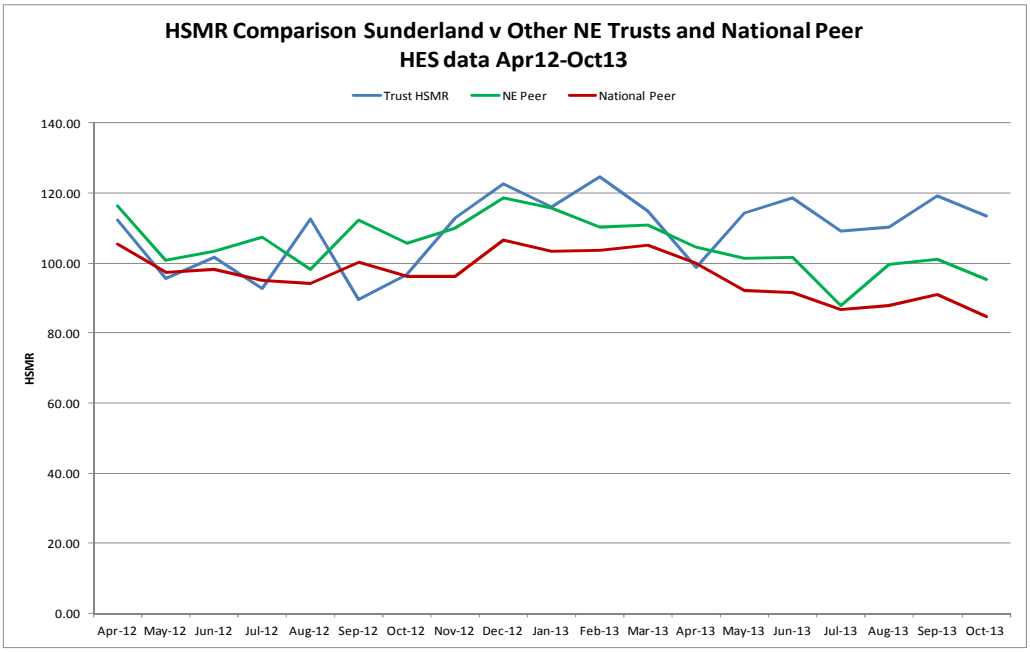
a) Reducing mortality

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

Information about the latest Summary Hospital-Level Mortality Indicator (SHMI) score has already been discussed in **Section 2**. This part covers two other national mortality measures;

Hospital Standardised Mortality Ratio (HSMR) - published by Dr Foster

The HSMR is a calculation used to monitor death rates in a Trust. The HSMR is based on a subset of diagnoses which give rise to 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS). The measure is published by Dr Foster Unit at Imperial College, London. As is common with other mortality measures, HSMRs should not be used in isolation, but rather considered with a range of other indicators that give a well rounded view of hospital quality and activity. City Hospitals does not use the Dr Foster (Intelligence) system.

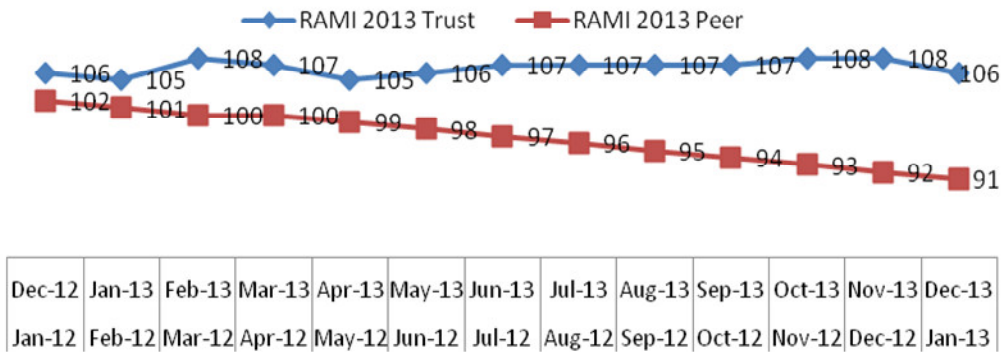


Data source – CHKS benchmarking report 2014 (internal document)

The chart shows that as the Trust HSMR increased between November 2012 – March 2013, this increase was also seen in the North East (NE) peer group, and to a lesser extent in the national peer group. However, since April 2013 the Trust HSMR has been higher than both the NE and national peer groups, both of which have seen a downward trend.

Risk Adjusted Mortality Index measure (RAMI) – published by CHKS

The Risk Adjusted Mortality Index (RAMI) is the CHKS measure of mortality and like SHMI is the ratio of the observed number of deaths to the expected number of deaths. However, risk adjustments within RAMI excludes deaths after discharge, any death coded as palliative care (Z51.5) and zero length of stay emergencies. For the year 2013 the crude mortality rate (all deaths) was 1.26% (1.47% for the peer) and the RAMI was 106 as in the previous year compared to a peer average of 91. As the RAMI index is a yearly calculation it is worth reviewing a 'rolling' year for this indicator (see below). This shows each year, for example from January to December 2012 then February 2012 to January 2013. The Trust index has fluctuated between 106 and 108 whilst the peer index falls from 102 to 91 and the national peer continues to fall.



CHKS benchmarking report 2014 (internal document)

At the beginning of 2014, the Trust commissioned a Mortality Measure Review by CHKS, in line with some other local Trusts in the North East. A group is currently reviewing the report in detail, which has raised some issues about clinical coding, particularly in relation to the accuracy of primary diagnosis, the relatively

low levels of emergency admissions, completion of death certificates and coding of co-morbidities and palliative care.

The Trust Medical Director has also been meeting with regional colleagues to develop a consensus on how local systems of monitoring and review can assist with a better understanding of what the various mortality measures explain about our performance. During 2014, we will introduce a Trust-wide mortality review panel to review all deaths occurring within the hospital, using a standardised screening tool and assessment on preventability. This will run in parallel with our new Mortality Review Group, convened by the Medical Director, to coordinate the systems and processes required to improve mortality, reduce avoidable deaths and ensure that the Trust learns the lessons from patient deaths.

Following receipt of the CHKS Annual Report 2013 a number of specific mortality outlier positions were identified and these have been further investigated through extensive case-note review and presentation of findings at Clinical Governance Steering Group. We have undertaken the following mortality reviews this year;

- fracture neck of femur - deaths in hospital within 30 days of emergency admission for hip fracture,
- percentage of deaths in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74,
- rates of deaths in hospital within 30 days of surgery: elective admissions; and
- deaths associated with pneumonia.

In most cases, there was little evidence of poor clinical management of the patient and the consensus was that these deaths were largely not preventable. However, there are some areas that we can improve, for example from the fracture of neck of femur review, we are developing an agreed shared care pathway between Orthopaedics and Elderly Medicine for elderly patients who require this orthopaedic surgery.

b) Never events

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

Description of Goal	11/12	12/13	13/14
Preventing occurrence of any 'Never Events'	4	1	1

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

An incident occurred in June 2013 involving a patient who had been admitted for a replacement of their nephrostomy (A nephrostomy is a tube that's used to drain urine from the kidney into a bag outside the body which can, on occasion, become blocked and requires changing). The patient had a bilateral nephrostomy and arrangements had been made to reinsert the right nephrostomy which had fallen out prior to admission. On return to the ward following the procedure, the existing left nephrostomy had been removed and a new nephrostomy inserted instead of the insertion of a new tube in the right side. However, the patient was scheduled to have a replacement to the left side nephrostomy as well. The patient received an apology and explanation in line with the principles of Duty of Candour and arrangements were made to have the right nephrostomy inserted the following day.

A full root cause analysis was undertaken to review what happened and agree any corrective actions. A modification to the existing WHO safer surgery checklist will be implemented in Radiology for any similar interventional procedures.

c) Patient Safety First Campaigns

During March 2013, City Hospitals participated in the 3rd National Nutrition and Hydration Week and set out a programme of activities designed to promote;

- the key characteristics for good nutritional care,
- protected mealtimes,
- the minimum standards for good nutrition in hospital,
- highlighting good nutrition and hydration practices, and
- continued education for professionals on good nutrition and hydration.

Some of the activities that took place during the week of the 17th March included;

- the Catering Team arranging kitchen tours for staff to observe the meals process 'in action',
- the availability of food tasting sessions in the main foyer for staff, relatives and visitors,
- visits by members of the Nutrition Steering Group to wards to provide support at meal times and seek views from patients, carers and staff about the new menu launch, and
- members of the Executive Team helping out in the Catering Department to show their commitment to good nutritional care.

As part of the campaign to raise awareness of incident reporting the Trust renamed September as ***Safe****tember.* One of the most successful activities was the Petcha Kucha event. This involved a rapid-fire series of presentations led by our Chief Executive which focused on issues such as clinical handover, the sepsis bundle, the national early warning score and patient involvement in safety. Certificates were then presented to the directorates of Obstetrics & Gynaecology, Theatres / Integrated Critical Care Unit and Emergency Care for their improved incident reporting rates. In 2014 the ***Safe****tember* event, to be held on the 17th September will be entitled 'Communicate: Mitigate or Litigate'.

d) Undertaking the Patient Safety Climate Survey

During 2013 City Hospitals took part in its first Patient Safety Climate Survey designed to establish a baseline measure of safety culture at the Trust. The Trust used an amended version of a questionnaire from the Royal College of Nursing to shift the focus to 'patient safety' rather than 'health and safety' more generally.

The questionnaire consists of a number of measures of staff perceptions of safety using nine dimensions, including management commitment, communication, priority of safety, supportive environment, personal appreciation of risk and aspects of the work environment. An action plan has been agreed to focus on some of the key recommendations within the report and plans are in place during 2014/15 to repeat the survey and measure the progress that has been made.

d) Dr Foster Good Hospital Guide 2013

The annual Good Hospital Guide, published by Dr Foster Intelligence, provides an independent assessment of NHS hospitals, based on patient data provided by hospitals and benchmarks the performance of every NHS hospital in England. In the 2013 report, City Hospitals performed 'as expected' or better than peer across a range of quality and safety indicators, including mortality, hospital readmissions, stroke care and management of fractured neck of femur. However, our palliative care coding rate was slightly lower than other hospitals and we are looking to understand the reasons why. Similarly our readmission profile suggests we have higher than average readmissions for some groups of patients and we will take action to improve these outcomes. Nevertheless, we are delighted with our overall performance in these key quality and safety areas.

Focusing on clinical effectiveness – "providing the best"

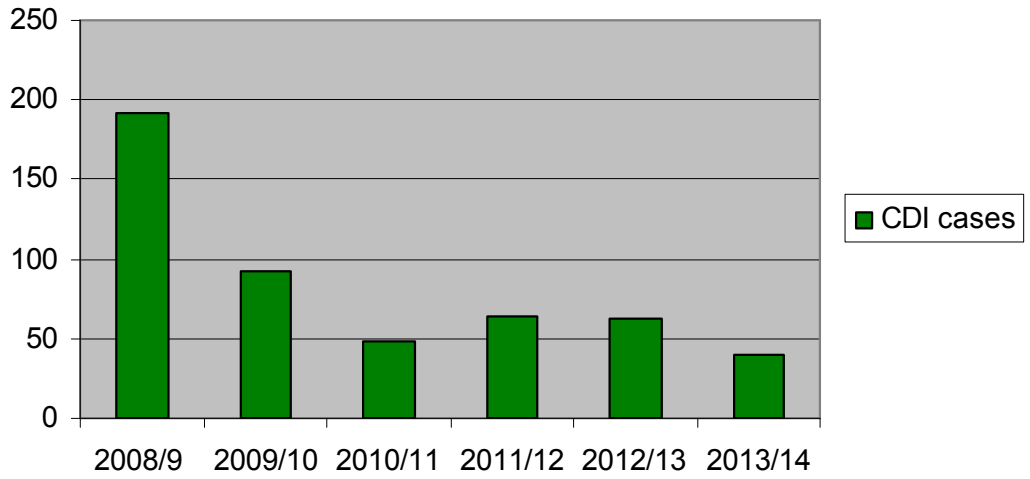
a) Reducing Hospital Associated Infection

The reduction of avoidable healthcare associated infection (HCAI) has remained high priority for the Infection Prevention and Control Team throughout this year with continued efforts towards embedding a zero tolerance for preventable infection.

This year's target of 0 (zero) MRSA bacteraemia set by the Department of Health has proven a significant challenge to the organisation. We are disappointed, that despite the increased efforts with hand hygiene, asepsis and surveillance we have failed to achieve our target. We have reported 4 cases of healthcare associated bacteraemia this year, however this does represent an improvement from the previous year's performance (6 cases).

Detailed root cause analysis of each individual case of MRSA bacteraemia has taken place and there is no evidence of any systemic failure of control processes within the Trust. We are able to report that only one of the Trust apportioned cases was deemed avoidable. Lessons learnt from each case continue to be shared throughout the organisation.

The target for *Clostridium difficile* infection (CDI) for 2013/14 was 36. This was a challenging target and there has been a huge drive, informed by the analysis of cases in 2012/13 to further prevent, reduce and control this organism. We have reported 36 cases this year (although we did report a further four cases but following discussion with Sunderland CCG and detailed case review it was confirmed that these were not genuine infections) and therefore the Trust achieved the target reduction of CDI. Again, this is a significant reduction compared to last year's report of 60 cases.



Source: Internal Infection Prevention & Control Department

Initiatives during 2013/14:

- installation of the 'virtual nurse' at the main hospital concourse, which provides a visual/audio messages to patients and their families as they come into hospital;
- the introduction of a patient prioritisation tool which enables assessment and identification of patients with known or suspected infection across the organisation;
- the trial of isolation pods on our Infection Control ward and general medical/ metabolic ward,
- additional touch point and toilet cleaning in identified high risk areas;
- the use of hydrogen peroxide to decontaminate identified areas of the hospital following environmental contamination;

- the introduction of a Healthcare Associated Infection Review Group to ensure open discussion of all cases of CDI with our Commissioners;
- completion of an extensive audit programme including a Trust wide decontamination audit,
- extended environmental screening targeting high risk areas; and
- the Infection Prevention and Control team successfully hosted its 3rd annual study day which was well attended by hospital staff.

The Infection Prevention and Control team is committed to working with colleagues throughout the organisation to sustain and make further improvements in infection prevention and control practice to reduce levels of healthcare associated infection even further.

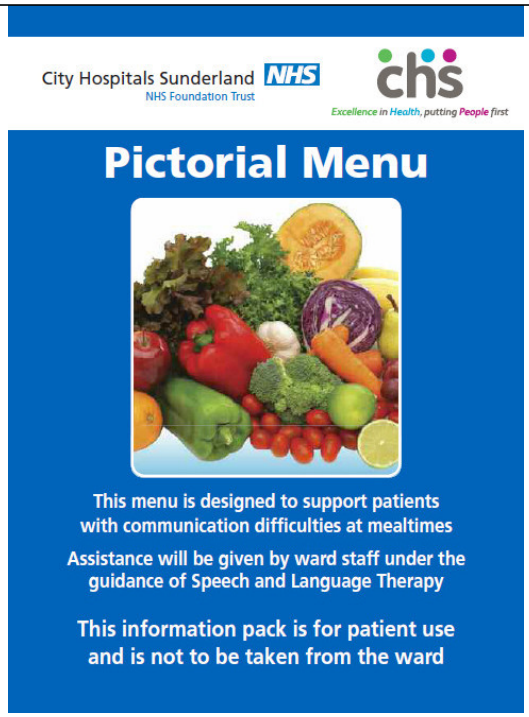
b) Improving Nutrition and Dehydration in hospital

Poor nutrition and dehydration can have a severe effect on a patient's health, wellbeing and general quality of life. Patients may have a reduced ability to fight infection, have impaired wound healing ability, reduced muscle strength and may develop apathy and fatigue. Wider health and wellbeing effects may include a reduced quality of life and a reduced ability to work, shop, cook and self-care. Patients who are malnourished also visit their GP more, have more hospital admissions as well as longer stays in hospital. Therefore it is vitally important that nutritional needs and dehydration status of patients, particularly the elderly, are adequately assessed and appropriately managed whilst in our care.

During 2013/14 the Trust Nutrition Steering Group (NSG) has focused on three specific work streams aimed at ensuring that patients receive a choice of nutritious meals and drinks to enhance their treatment and recovery.

Service Improvements in 2013/14

- A picture menu has been issued to all wards to assist visual representation of the meal and drink choices available to patients. This is also available in an electronic format and has been uploaded onto the intranet to improve accessibility of the document for staff;



- The ward teams on E53 and E58 are currently piloting new sets of crockery to determine the impact that a contemporary design has on the patient's perception of meals/choice, and
- In November 2013 a group of secondary school children participated in a Catering Department Assembly Unit tour and talk about the importance of food for patient's health and well being. This provided an opportunity to seek the views of the teenagers about the menu, choices and provision of food/drink that we have available. The visit enabled hospital staff to listen to what the teenagers thought about the menu, which proved to be very positive and is something we will build on for 2014/15.

Education of Staff

- Two Trust wide conferences: The Patient Experience Symposium and The Health Care Assistants' Development Day included presentations on the importance of nutritious meals/drinks for patients, local choices available for patients, preparing patients for meal times and a demonstration as to how food should be presented to patients, and
- Alongside the formal presentations the food and drinks provided to delegates throughout the day were exactly the same as that being offered to our inpatients.

Monitoring of Compliance

- The Catering Team monitor patient comments regarding food choice, quality and waste through complaints, Friends and Family Test responses and speaking direct to patients on the ward,
- The Nutrition Steering Group regularly meets with Ward Managers about the provision of food for their patients and has recently introduced a series of unannounced meal time visits to wards, including observations of meal preparation, patient choice "in action", conduct of the meal service and identifying any training needs for staff,
- A number of actions have been undertaken to improve protected mealtimes, including reducing medical staff activity at mealtimes, unless there is an emergency, and reducing the number of staff who visit the wards for a specific purpose, such as topping up cupboards, looking for equipment or checking patient level detail at mealtimes.

c) Participation in 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 2013/14, there were eight tumour sites that underwent Self-Assessment (SA) with Internal Validation (IV) in 2013/14. Of those, three were additionally Externally Verified (EV) by the national team; Lung, Colorectal and Penile. One tumour site underwent a Peer Review visit (PR), Chemotherapy. The tumour sites for peer review change each year so we are not able to provide comparative data.

Cancer tumour site	Compliance	Type of assessment
Upper Gastro-intestinal	90.3%	SA, IV
Cancer Unknown Primary	76%	SA, IV
Haematology	83.3%	SA, IV
Breast	87.5%	SA, IV
Colorectal (plus 'locality' review)	94.4%	SA, IV, EV
Head & Neck (plus 'locality' review)	92.1%	SA, IV
Lung	80%	SA, IV, EV
Penile	75%	SA, IV, EV
Chemotherapy	83.3%	PR

Action plans have been developed by each cancer multidisciplinary team related to the outcomes of the peer review exercise. There are changes to Cancer Peer Review 2014/15 and the internal and external assessments that support the national programme. Tumour groups will continue to be targeted for external visit and review and Breast MDT will be part of a formal review later in 2014.

d) Clinical Outcomes (Surgeon-level data)

In 2012 NHS England announced that it would require publication of surgeon-level outcomes data in 10 specialties, by the summer of 2013. The mandate to publish individual surgeon results largely came from the legacies of the Kennedy Report (2001) that dealt with the adverse cardiac surgery outcomes in Bristol and more recently the Mid Staffordshire enquiry that culminated in the Francis Report (2013). The hospital failings found in both reports highlighted the need for more clarity about individual surgeon outcomes as part of a process of encouraging continuous quality improvement.

In June 2013 the first set of outcomes and mortality rates for individual hospital consultants were published nationally based on data from the national clinical audits and clinical registry. The data appears on NHS Choices and covers a range of operations and procedures. It shows the number of times a consultant has carried out a procedure, mortality rates and whether clinical outcomes for each consultant are within expected limits. The data has been reviewed for relevant Trust consultants in each of the nominated clinical audits and registries. A high-level summary of the outcomes for each are highlighted below;

Specialty	Outcome
Bariatric Surgery (surgery to treat obesity)	As expected
Interventional cardiology (heart disease treatments carried out via a thin tube placed in an artery)	As expected
Orthopaedic Surgery (surgery for conditions affecting bones and muscles)	As expected
Thyroid and Endocrine Surgery (surgery on the endocrine glands)	As expected
Urology Surgery - surgery on the kidneys, bladder and urinary tract	As expected
Vascular Surgery (surgery on veins and arteries)	As expected
Colorectal surgery (surgery on the bowel)	As expected
Upper gastrointestinal surgery (surgery on the stomach and intestine)	As expected
Head and neck cancer surgery	As expected

* Adult cardiac surgery (National Adult Cardiac Surgery) – not undertaken at City Hospitals

In City Hospitals Sunderland, none of the surgeons reported had outcomes outside the expected range given their associated risk adjustment and levels of activity. The report therefore provides robust and satisfactory assurance on the clinical performance of surgeons in these key areas.

Focusing on patient experience – "listening to you"

Thoughts, opinions and observations of patients and relatives who use our hospitals and services are very important to us. Our aim is that every patient's experience is an excellent one and understanding what matters most for our patients and their families is a key factor in achieving this.

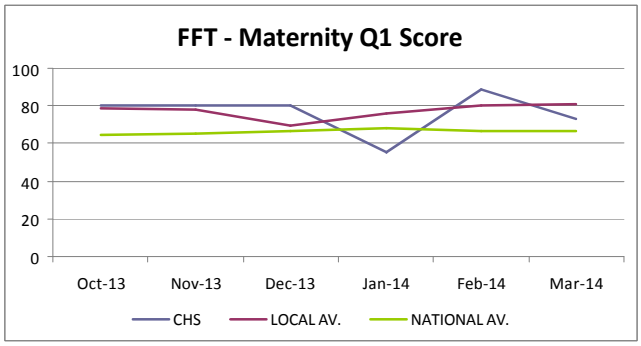
a) Introducing the Maternity Friends and Family Test

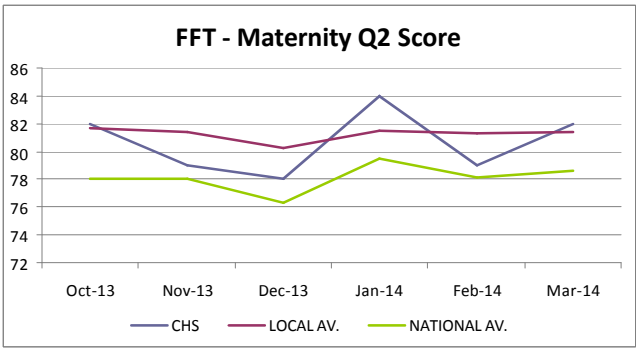
The Maternity Friends and Family Test started on the 1st October 2013 and asks women questions at three stages during their pregnancy; seeking feedback about antenatal services, the labour ward/ birthing unit, the postnatal ward and the postnatal community services. They are asked whether they would recommend maternity services to others based on their own experience. The scores below in table and chart format

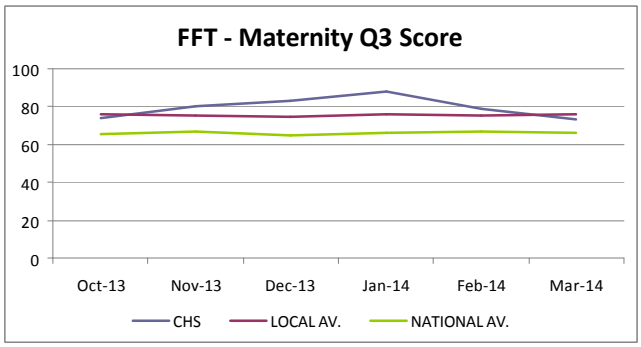
provide an encouraging picture of how patients would recommend the maternity service to others, with performance exceeding national and some local averages.

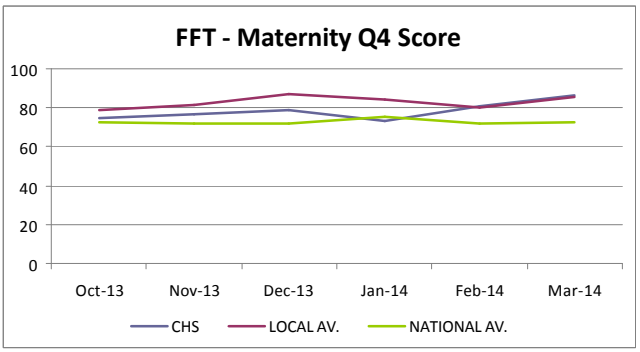
Question related to:		Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Q1	Antenatal experience	80	80	80	55	89	73
Q2	Birth experience	81	79	78	84	79	82
Q3	Postnatal experience	74	77	83	88	79	73
Q4	Postnatal community experience	75	79	79	73	81	86

Maternity Friends and Family Test net promoter scores (Scale -100 to +100)









Source – NHS England (Friends and Family Test data)

Similar to the Friends and Family Test for inpatients and Accident and Emergency, respondents can provide additional free text comments. Examples received to date include;

- *"I like the way they always listen and always there for advice when needed",*
- *"Midwife is very good and they advise us whenever we need. I'm very happy they are my midwife, my baby and me are in safe hands",*
- *"No problems everything is great",*
- *"Birthing pool relaxing",*
- *"Everything was really good. Don't need to improve anything",*
- *"Very supportive for my first pregnancy looked after well",*
- *"Personal care from midwife, communication following birth to going home",*
- *"Room was cold at night time but that was the only negative", and*
- *"Food not wonderful".*

In addition, staff who are individually named, in a positive way, in free text comments are sent a letter of commendation by the Director of Nursing and Quality. If negative comments are received these are anonymised before results are publicised, however a copy is sent to the relevant line manager for action.

b) National Patient Survey programme

The National Patient Survey Programme is part of the government's commitment to ensure that patient feedback is obtained so that it can be used to drive improvements in healthcare services. Each Trust is legally obliged to carry out a survey of patients' views on their recent hospital experiences. Feedback from these surveys allows organisations to compare their results and helps to identify where they have performed well and highlights gaps which require improvement.

For 2013/14 City Hospitals participated in the following national patient surveys;

Type of survey	Data collection	Date of publication
Emergency and elective inpatients	Sept 2013 – Jan 2014	April 2014
Chemotherapy survey	Jan – April 2013	Feb 2014
Women's experiences of maternity services	May – August 2013	Dec 2013
Cancer patient experience survey	Jan – April 2013	July 2013

National Adult Inpatients Survey (2013)

The national survey of adult inpatients provides an opportunity for patients to give their views on the service they have received from City Hospitals. It remains one of the largest surveys of patient experience in hospital of its kind. The questionnaire asks patients to comment on topics ranging from their admission process, hospital cleanliness, privacy and dignity, hospital food, to communication with staff, discharge planning and their overall hospital experience. Questionnaires were posted to 850 people, in line with the national sampling strategy, and 444 were returned complete, giving a response rate of 53% (the national rate was 49%).

The results show that across the 60 questions which measure our performance from the patient's perspective, 58 (97%) are in the amber 'expected range' category, meaning that we are about the same as most other Trusts in the survey. There were no questions and scores in the green category rated as the best performing Trusts. However, we did have 2 questions in the red or 'worse' performing category. It is disappointing to report once again that one of these questions relates to choice of food despite the number of Trust initiatives and staff awareness campaigns that have continued throughout the year. The other 'red' area is about staff failing to adequately answer patient's questions about their operation or procedure. This has never been reported in the 'worse' category before and we need to look at the factors that may have contributed to this rating.

The 'section' table highlighted below provides an aggregated score for questions grouped according to the sections in the inpatient questionnaire. A higher score is better.

Score	Section themes	Rating compared with other Trusts		
8.4/10	The Emergency Department / A&E Department	WORSE	ABOUT THE SAME	BETTER
8.7/10	Waiting list and planned admissions	WORSE	ABOUT THE SAME	BETTER
8.0/10	Waiting to get to bed on a ward	WORSE	ABOUT THE SAME	BETTER

8.0/10	The hospital and ward	WORSE	ABOUT THE SAME	BETTER
8.5/10	Doctors	WORSE	ABOUT THE SAME	BETTER
8.0/10	Nurses	WORSE	ABOUT THE SAME	BETTER
7.3/10	Care and treatment	WORSE	ABOUT THE SAME	BETTER
8.2/10	Operations and procedures	WORSE	ABOUT THE SAME	BETTER
7.2/10	Leaving hospital	WORSE	ABOUT THE SAME	BETTER
5.3/10	Overall views and experiences	WORSE	ABOUT THE SAME	BETTER

Each Trust is also assigned a category, to identify whether their score is 'better', 'about the same', or 'worse' than most other Trusts who carried out the survey. City Hospitals achieved an 'about the same' rating for each of the 10 sections compared with other Trusts.

The tables below show where the Trust has achieved the largest increase and decrease in scores for individual questions compared to the last survey in 2012.

Survey questions – comparison of 2012 and 2013 results		2012	2013	
Questions that have increased our scores the most (higher score is better)				
Q3	While you were in the A/E department, how much information about your condition or treatment was given to you?	7.8	8.4	↑
Q23	Did you get enough help from staff to eat your meals?	6.7	7.5	↑
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	0.9	2.2	↑
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.9	2.7	↑

Survey questions – comparison of 2012 and 2013 results		2012	2013	
Questions that have the greatest 'loss' in scores, i.e. worse than the last survey				
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	5.8	5.2	↓
Q35	Do you feel you got enough emotional support from hospital staff during your stay?	7.2	6.7	↓
Q54	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	7.0	6.4	↓
Q55	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.5	8.0	↓
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.9	7.1	↓
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	6.8	6.0	↓

The results of the inpatients survey (2013) have been presented to the Patient, Carer and Public Experience Committee (PCPEC). They will monitor the progress of any actions that have been agreed to address areas that require the most improvement.

Women's experiences of maternity services (2013)

In December 2013 the Care Quality Commission (CQC) published the results of Women's experiences of maternity services. Similar surveys had been carried out in 2007 and in 2010. The 2013 maternity specific survey involved 137 NHS acute trusts in England. Women were eligible for the survey if they had a live birth during February 2013, were aged 16 years or older, gave birth in a hospital, birth centre, a maternity unit, or had a home birth. In total 133 women who delivered at City Hospitals responded to the survey giving a response rate of 44% (46% nationally). The benchmarking reports compare antenatal care, postnatal care and labour and delivery care with other Trusts.

- Maternity care pathway report (**Antenatal care**) - the results show that across the 9 questions relating to antenatal care, 7 are rated 'about the same' as most other Trusts in the survey. There were no scores in the 'better' category. However, we did have 2 questions rated 'worse' than other Trusts. These relate to '*offering choices where to have your baby'* and being *'given Information to help decide where to have your baby'*. During 2013, our real time feedback results also highlighted these issues and we have already made improvements by providing information leaflets to patients regarding place of birth choices. We have plans to include a dedicated section in the hand held records to prompt questioning around choice of place of birth. In addition we have developed a promotional DVD to help inform patients of birth choices which will also be available on the Trust internet site.
- Maternity care pathway report (**Labour and birth**) - the results show that across the 17 questions relating to care during labour and birth, 16 (94%) are rated 'about the same' as most other Trusts in the survey. There was one question where performance was classified as 'better' than other Trusts, related to information and explanations given to women.
- Maternity care pathway report (**Postnatal care**) - across the 18 questions relating to postnatal care, 17 (94%) are rated 'about the same' as other Trusts. There was one question where performance was 'better', linked with women having an awareness of contact details for their midwife.

The Obstetrics and Gynaecology Clinical Governance Group has reviewed the findings of the survey and is overseeing the implementation of an action plan to address some of the shortcomings. The results have also been presented to the Patient, Carer and Public Experience Committee.

c) Real Time Feedback

We continue to use real time feedback to listen and respond to patients' views. This is a simple and quick way of finding out from patients about their hospital experience so that we can focus on things that they tell us. As in previous years we are grateful to our network of Trust volunteers who help to collect the feedback from patients. During 2013/14, we have had feedback collected from 2,527 general inpatients, 320 parents of children on paediatric wards, 218 children themselves and 137 women in maternity. That represents just over 3,200 questionnaires, the busiest year so far, and information from the questionnaires is reported back to the wards to help improve the service if appropriate.

What improvements have we made during 2013/14?

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

Ward Type	Improvements made in 2013/14
Maternity services	• Fathers expressed a wish to stay with their wives/ partners following the birth of their baby. The Directorate acquired recliner chairs, set robust criteria and now offer fathers an overnight stay for the first night post delivery. This has been well accepted and received positive comments • Following delivery of their baby, women were often hungry and had to wait until set mealtimes or did not want meals offered. The Directorate acquired a toaster to enable women to have tea and toast outside of set mealtimes. This has also been well received
Paediatrics wards	• Every morning the choice of meals from that day's order sheet are discussed with each child or parent, therefore allowing a personalised meal service • Wards now offer small individual pots of fresh fruit salad and serve the lunchtime sandwiches in a 'happy-meal' style box much to the delight of the children
Medical and surgical wards	• Ward D46 are currently arranging to have a water cooler installed after feedback from some patients who thought the water from the ward kitchen wasn't cold enough (Urology – male) • Ward C36 have changed their hot meal to lunch time so that sufficient staff are available to ensure meals are hot / well presented / patients are given assistance if required / and trained nurses are available (Vascular ward) • Ward C31 has purchased a wall mounted flat screen TV as patients were waiting in the day room for some time for their bed to become available. Complaints due to excessive waiting have consequently reduced • On Ward C36 patients complained about waiting for their dressings to be done. Ward shift patterns have now been adjusted to allow for an extra trained nurse on days where dressing changes are due. There are now only occasional delays and generally the new way of working has been successful • The Trust is currently undertaking unannounced visits to wards at meal times to review local practice, reinforce patient menu choices and observe portion sizes and presentation of food. The visits also enable the team to see whether patients who require assistance with their meals are given this important help

Plans for 2014/15

In April 2014, we will introduce a new real time feedback questionnaire and establish a revised, simpler, reporting format to the wards. The new design is the culmination of work done earlier in the year to refresh the questionnaire so that it remains relevant and meaningful to the organisation. Further amendments were made to accommodate a selected number of patient experience questions in the new "Open and Honest Programme" which we are required to report nationally. The results from these particular questions will be uploaded to a new Open and Honest web portal with selected data been made available on public facing information boards on wards throughout the Trust.

d) Listening to patients – learning from their 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.

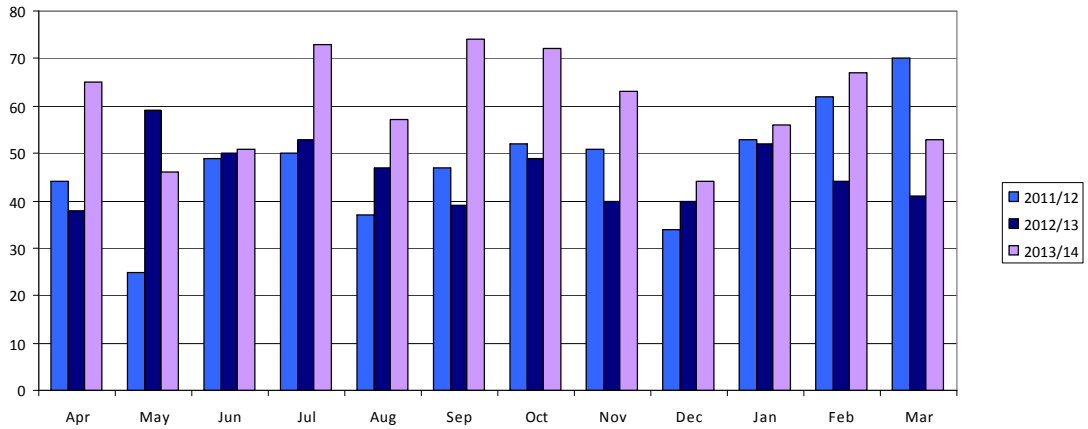
A Rapid Process Improvement Workshop was undertaken in March 2013, to review the work of the Patient Advice and Liaison Service (PALS) and Complaints Department, with a number of actions being identified to improve the complaints handling process and provide a more individualised timely response for patients and their families. The new process has been incrementally implemented across the Trust during 2013/14 with implementation completed in January 2014. The process involves 'triaging' (determining the priority) of complaints, into three levels; red (complex multi agency/specialty complaints), amber and green

(complaints that could be dealt with over the phone). The aim is that all complainants receive early contact by telephone to agree the issues, response time and response format.

In September 2013, Internal Audit identified a number of concerns about the complaints handling process in the Trust. As a result of this audit, and subsequent national recommendations published in the Clwyd and Hart Review (November 2013), a number of additional actions have been identified to further improve the complaints handling process. These actions are being monitored by the Patient, Carer and Public Experience Committee.

We aim to provide timely responses to complaints, but recognise that this does not always happen which potentially can have a negative impact on the complainant. Most of these delays occur due to the time taken to carry out and complete the investigation process within the directorates. In going forward, the Trust has agreed to the appointment of four new quality and risk facilitators to support directorates in completing their investigations of both incidents and complaints. In addition a significant upgrade is planned to the Trust Safeguard software system (which provides the complaints management system) in 2014/15.

Comparison of complaints activity 2011/12 to 2013/14



From 1 April 2013 to 31 March 2014 the Trust received 721 formal complaints from patients or their representatives. This is a 29% increase on the 559 received last year. We have moved the Complaints Office from Trust Headquarters across to the main hospital concourse so that it is much more visible and accessible to the public. Wards have also raised awareness through posters regarding the arrangements for those wanting to make a formal complaint. This may explain, in part, why we are dealing with more complaints. We want to encourage feedback from patients and their relatives so we can improve our services.

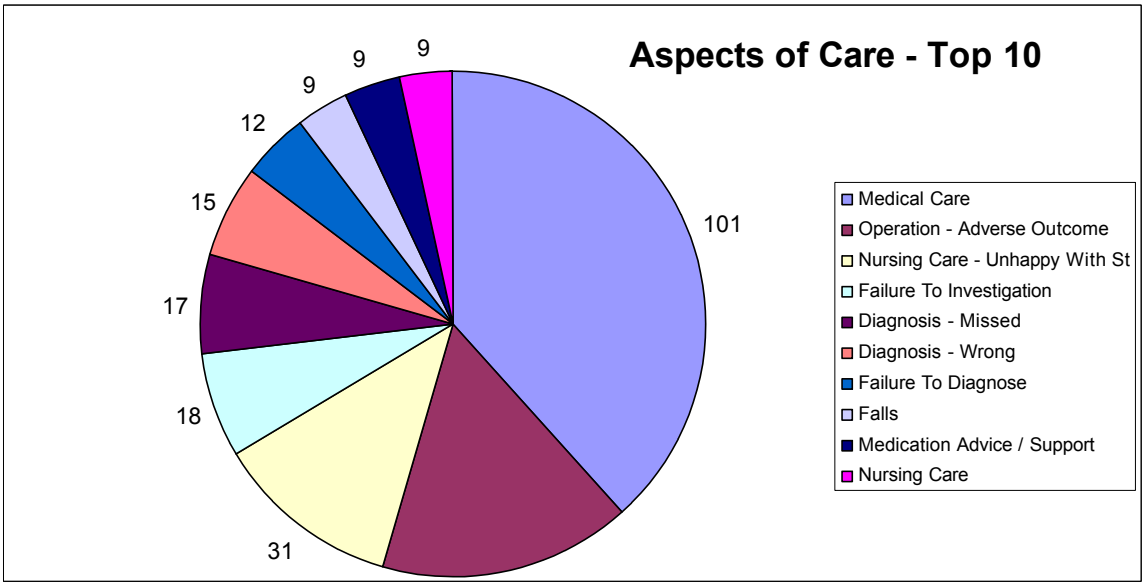
Types of complaints received

Whilst most complaints have more than one theme, all are allocated a “primary theme”. During 2013/14 complaints related to the following primary themes:

Primary theme	Total	%
Commercial Decisions Of Trust (commissioning issue)	1	<1
Infection Control	1	<1
Transport	1	<1
Other	1	<1
Privacy and Dignity	2	<1
Medical Records	2	<1
Consent	4	1
Policy And Procedures	4	1

Information Governance	5	1
Aids and appliances	6	1
Patient property and expenses	7	1
Environment	10	1
Estates/Support/Hotel Services	26	4
Admission / Discharge/ Transfer	33	5
Appointments Delay / Cancellation (In Patient)	34	5
Attitude of Staff	47	7
Communication	94	13
Appointments Delay / Cancellation (Out Patient)	111	15
Aspects Of Care	332	46
Total	**721**	

Aspects of care account for the highest number of complaints and there are 26 issues identified within this theme. The top 10 are detailed below:



During 2013/14 we began developing a new internal system for monitoring complaint response times, i.e. those resolved within 25 working days. Work is still ongoing to refine the process and we will report on this measure on a regular basis to the Patient Carer and Public Experience Committee.

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 our service as a result of patient complaints.

Patients Said	Changes Made
The out patient appointment system was confusing, appointments were sometimes cancelled before patients had actually received the appointment date and it was difficult to contact the appointments centre	We have undertaken a review of the entire scheduling process to ensure patients receive timely appointments, and staffing of the appointment centre has been reviewed.
Patients told us they sometimes received a follow up appointment before they had had the investigations that were required before their next appointment. Patients and GPs also told us that sometimes they did not receive clinic letters in a timely way	We are piloting a “Clinic on the Day” process in 5 out patient areas. Patients involved in the pilot leave the out patient department with a follow up appointment, dates for follow up investigations and in some areas, patients receive their clinic letter.

They had not been kept informed about their treatment plan or staff did not communicate what was planned for their care.	We reviewed our existing "comfort rounds" on two wards which resulted in improved communication, reduction of pressure ulcers and falls, improved pain management and overall patient satisfaction. This will be rolled out to other wards in 2014/15
They were unhappy with long waiting times in the Emergency Department and often did not understand the reasons for waiting	We introduced a "Navigator Nurse" in the Emergency Department whose role is to direct the patient to the right person first time with the aim of reducing delays for patients. Duty rotas have also been amended to record name of Navigator Nurse to ensure accountability for decision making
People smoking at hospital entrance areas was offensive and unacceptable	We have increased signage to encourage smokers to use the shelters provided and a No Smoking statement is included as part of out patient letters. The security team regularly monitor main areas and smokers are challenged at peak times by senior staff
They did not know how to make a complaint and that accessing information about making a complaint was difficult.	Information about how to make a complaint, and a copy of the complaints form has been uploaded onto the Trust website, the Complaints and Patient Advice and Liaison department staff have been co-located on the main site, and posters and leaflets advising patients how to make a complaint have been replenished throughout the organisation
Nurses sometimes appear preoccupied with computer work and were not on hand to answer queries and provide care	We recognise that access to computers is an essential part of the nurse's role as patient records are completed electronically. However in some wards we have put laptops in the patient bays to ensure staff caring for patients are more easily accessible, and nurses can remain with patients whilst completing records
Women wanted more birth choices and did not want to travel to other maternity hospitals, specifically to labour and birth in water	We provided a birthing pool in our Delivery Suite which opened in August 2013. To date we have had 70 successful water births with over 120 women using the pool
Our outpatient letters were too vague and lacked important and helpful information such as the name of the consultant	Following consultation with patient representatives appointment letters have been revised and now include clinic details and the name of the consultant

e) Ward Assurance Visits

The Quality Assurance Ward Visit Programme is part of the Trust Assurance Programme. It provides an opportunity for the Director of Nursing and Quality and other executive and non-executive directors to visit wards and department areas and provide feedback on their findings/views to staff and at Board of Director meetings. The 'go, look and see' model is fundamental to the principles of *Lean* but also provides a different perspective to quantitative data, i.e. that which is measured on a numerical scale. A key finding of the Francis Inquiry was an over-reliance on data, without regard to observing what was really happening and listening to staff and patients. It is important from a Board perspective that there is an assurance mechanism in place on how care is delivered at the frontline. The visits also provide an opportunity for directors to hear directly from staff and patients about good practice.

Many of the issues identified are addressed and rectified immediately at the time of the ward/dept visit. These are discussed with the ward/department sister or charge nurse, or registered nurse in charge at the time.

Issues highlighted during the ward visits in 2013/14:

- bare below the elbows (an initiative aiming to improve the effectiveness of hand hygiene performed by hospital staff) is noticeably firmly embedded in practice;
- National Early Warning Scores (NEWS) are appropriately documented for each patient;

- general impression of the clinical environment on most wards/departments is very good;
- majority of feedback from patients regarding their meals remains positive although menus not always available;
- majority of comments from patients and relatives/carers regarding clinical care are positive;
- majority of feedback from patients about care delivery/experience/environment/communication with staff is positive;
- some patients (largely those with delirium/dementia) do not have identification (ID) wristbands as they have removed them;
- there is 'on the spot resolution' of patient/relative/carer concerns which are expressed during ward/department visits;
- estates work is followed up at time of visit/jobs referenced and allocated to appropriate personnel by the estates representative;
- some patient information boards on wards and departments are not always up to date.

Ward and department visits will continue to take place fortnightly. There is now also representation from our Commissioners for some of the visits which adds to the integrity and robustness of our assurance approach.

f) Patient Advice and Liaison Service (PALS)

PALS is a first stop service for patients, their families and carers who have a query or concern about the hospital or service. The team provides an impartial and confidential service and aims to help resolve issues by addressing them as quickly as possible. Where PALS is unable to help, the enquirer is directed to a more appropriate person or department. The majority of PALS contacts relate to requests for information about hospital processes or putting people in touch with the correct department or individual who can help them.

The service collates comments, suggestions and concerns made either directly to the service or by the patient experience feedback mechanisms available throughout the hospital. A report is prepared for the Patient Carer and Public Experience Committee on key themes for patient concerns.

PALS is an integral part of the Patient Experience Team and works closely with the Complaints Department to provide a seamless and comprehensive service to patients and their families.

During 2013/14 PALS dealt with 903 requests, compliments and concerns. The main concerns relate to outpatient appointments, aspects of care and communication.

g) Volunteers

Trust volunteers provide a valuable service that involves spending time, unpaid, to support Trust staff in delivering a quality service. Their role is to complement the work of paid staff and they are therefore not included in staffing numbers. All volunteers undergo a series of pre-employment checks and are subject to an interview. We have approximately 280 volunteers registered in the Trust who undertake a variety of roles which include: assisting with administration, befriending patients, meeting and greeting visitors, supporting clinical staff at meal times, answering the telephone and collecting feedback from patients.

h) Carers

City Hospitals continues to work closely with staff and carers from Sunderland Carers' Centre to improve the experience of the many patients and carers who use the facilities. A Carers Reference Group meets quarterly to discuss issues raised by carers and the meetings have had a positive impact at the Trust.

The Carers' Centre have told us that carers often do not identify themselves as carers, and they therefore they miss out on valuable opportunities for support and assistance. The Trust has implemented a number

of initiatives to raise awareness of carers and once identified staff can signpost to the Carers' Centre for support. Part of our awareness campaign during 2013/14 included, installing a Trust-wide computer screen saver promoting carers, which coincided with national Carers' Week. In addition key messages about carers are incorporated into a range of existing educational courses and study days.

The Carers' Centre continues to be involved in training thus providing an excellent opportunity for staff from the Trust, including medical staff to gain first hand experience of the role of a carer. The Carers' Centre is also involved on our recruitment panels for staff nurses.

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

i) Community Panel

The Community Panel, established in 2001, comprises a lay group of volunteers who play an important part in our commitment to patient and public involvement, providing a forum for participating, reporting, reflecting on and improving the patient experience in hospital. In 2013/14, we can report further examples of their activities:

- leading the feedback collection from patients on wards who participate in Real Time Feedback;
- participating in the review of the Real Time Feedback process and questionnaire;
- for the 10th year running helping with the Patient Led Assessment of the Care Environment (PLACE formerly PEAT) inspections and making sure that the process is objective, fair and accurate;
- participating in a number of study days and workshops including the Patient Experience Symposium, Health Care Assistant Development Day and Infection Prevention and Control Study Day;
- one of our Panel members provided a patient perspective in the workshop which was held to redesign the endoscopy unit;
- undertaking an audit of the waiting areas at Sunderland Eye Infirmary and contributing to the subsequent improvement plan; and
- ongoing, active contributions to a number of Trust working groups and committees.

j) Patient-Led Assessment of the Care Environment (PLACE)

Good hospital environments matter. Every NHS patient should be cared for in a clean, safe environment and where standards fall short, actions should take place to improve them. April 2013 saw the introduction of PLACE, which is the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments require local people to go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The assessments take place every year, and results are reported publicly to help drive improvements in the care environment.

City Hospital's unannounced inspections took place in April 2013 at both the Sunderland Royal Hospital and the Sunderland Eye Infirmary. This year four inspection teams were formed to cover the selected areas, taking care to avoid any disruption to patient activity. Each team was required to undertake a series of inspections with areas selected by the Patient Representatives themselves at the start of the day. Following each inspection an assessment form was completed and scoring agreed by all members in the team.

The national results were published in September 2013. Given that our performance in the previous PEAT programme was always very strong, we were disappointed to see that our scores fell short of the national average and were the lowest in the region. We are confident that we have applied the strict PLACE process robustly and that the data submitted was an accurate reflection of our findings on that day. Although not a requirement of the process, Peer Review (external validation) was recommended. We were one of only a handful of hospitals who included this as part of the PLACE process.

Listed below are the scores for the Sunderland Royal and Eye Infirmary and the national average;

	Cleanliness	Food	Privacy	Condition
National average	95.74	84.98	88.87	88.75
Sunderland Royal Hospital	94.74	75.43	75.47	89.77
Sunderland Eye Infirmary	93.85	88.24	83.87	86.48

The findings from PLACE inspections have been developed into an action plan and have been shared with the Multi Disciplinary "National Standards of Cleanliness Group" to drive forward specific actions identified for individual wards and departments. This group has also identified key Trust Wide issues and made recommendations for action. Food and hydration actions already form part of the Nutritional Steering Groups action plan and are being actively progressed by this group.

This finding have also been shared with Divisional General Managers at the Operational Management Group (OMG), and cascaded to their respective teams. The report has been discussed with the G4S Domestic Team at the contract review meetings. Actions are already under way on areas of particular concern, with follow-up visits by Infection Prevention and Control and the Domestic Monitoring Team, who are working closely with ward teams.

k) Pets as Therapy

Pets as Therapy (PAT) is a national charity providing therapeutic visits to hospitals, hospices, nursing and care homes and a variety of other establishments from volunteers with their pet dogs. The dogs are temperament tested and have full vaccinations, and the aim is to bring comfort and companionship to people by giving them the opportunity to stroke, hold, and talk to one of these calm and friendly dogs.

Research shows that for patients, there are therapeutic benefits in having contact with animals, particularly for children and older people, with the contact helping to normalise situations such as hospital stays. There is also some evidence that the dogs have successfully aided rehabilitation from serious conditions, particularly of stroke patients.

The Trust agreed to pilot the idea of using PAT as a therapeutic aid for patients recovering from stroke. A PAT volunteer and her dog Buster (a Shihtzu) commenced visits to the Stroke Ward on E58 in December 2013 following completion of her Trust Induction. These visits occur weekly usually at weekends although some have occurred during the week. The visits follow strict infection prevention and control guidance developed by the Royal College of Nursing and the PAT Charity.

Buster has had a profound effect upon a number of patients on Ward E58 as these comments testify;

"Seeing and being able to interact with such a lovely animal is a real pleasure, he is lovely!"
"This was a very pleasant experience, bringing pleasure to both myself and other patients in very difficult circumstances. Thank you Buster"
"This really lifted my mood. I was pleased to see him and it helped pass the time."
"This really boosted me up, lifted my mood as I was really missing my own dog".

One of our Stroke Specialist Nurse Practitioners has also commented;

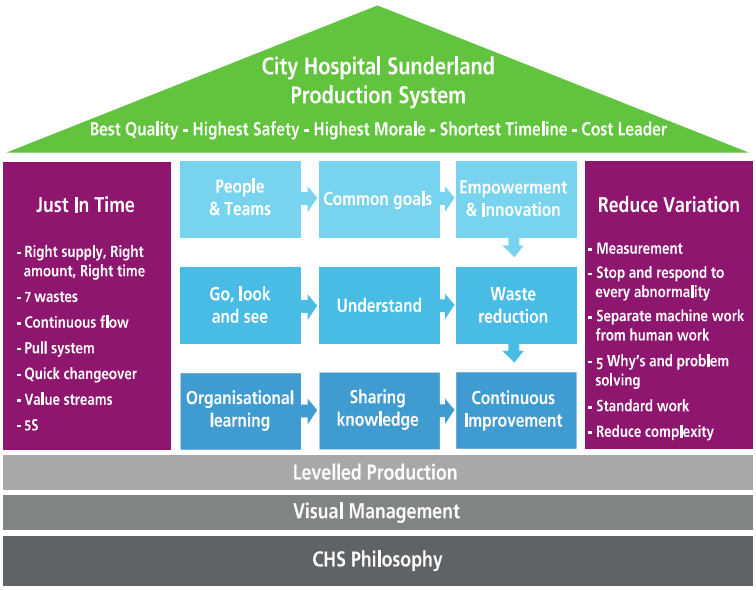
"E58 has recently had the pleasure of participating in the innovative practice of 'pet therapy.' I cannot emphasise enough the pleasure patients receive when the 'star' of the show 'Buster' arrives on the ward. We have had a number of patients who have been low in mood and withdrawn, showing no participation in therapy or communication and declining human contact yet they have responded instinctively and positively to Buster. The experience of 'pet therapy' on E58 is definitely a positive one which can only contribute to positive patient experience, patient recovery and rehabilitation".

Buster, her owner volunteer and patients and staff have also featured in the local Sunderland Echo and BBC Radio Newcastle.

l) Improving quality using a *Lean* philosophy

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

The CHS Production System is our interpretation of *Lean* philosophy and our approach to support the delivery of safe, effective care and a first class patient experience (see 'house' diagram below).



The Kaizen Promotion Office provides continuous improvement facilitation to a number of projects across the organisation. The mainstay of our improvement work in 2013/14 has focused on the implementation of Meditech Version 6, supporting clinical and administrative teams to develop processes and information flow using the new clinical record and scheduling system. Some of our projects include:

"Clinic on the Day"

Five directorates have been piloting processes to ensure that patients leaving the outpatients department have a written summary of their consultation and a forward plan, in the form of a copy of the clinic letter which is sent to their GP. Furthermore, if diagnostic tests are required e.g. X-ray, CT scan and/or endoscopy these are ordered by the clinician and an administrator books a convenient appointment for the patient before they leave the department. Early indications from patients are that they find this service valuable and a big improvement. One patient commented:

"I can't believe I have come in, been seen, agreed a date, got a letter. I feel like a private patient. I thought you only get this type of service if you went private and paid for it."

We are now planning to extend these processes further across the organisation throughout 2014.

Improving the communication of diagnostic test results

Whilst we have very timely processes for communicating with patients who have had positive diagnostic tests and require treatment, we do not always communicate with patients quickly to tell them when results are normal. This leaves patients sitting at home wondering and worrying about the results, which leads to unnecessary telephone calls to the hospital and patient frustration and complaints. The efficiency of the process to review and communicate test results has been improved which in turn has reduced the delays to patients being informed.

Developing a high quality clinical environment

The Kaizen Promotion Office has also supported two large projects to improve the work environment in key clinical areas; 'D Level' Day of Surgery Admission and Centralisation of PREP (Pre Operative Assessment and Preparation). These have provided important benefits for patients and staff.

Part 3.1 Performance against key national priorities 2013/14

Performance against National Measures

During 2013/14 the Trust has continued to achieve national operating standards across a number of key measures including cancer waiting times, waits from GP referral to treatment and diagnostic waits.

The NHS Planning Framework for 2013/14 included indicators which measure delivery of the NHS Constitution and some which are assessed as part of Monitor's assessment of Foundation Trusts governance risk rating. Monitor, the regulator of Foundation Trusts, has changed its approach to risk assessment during 2013/14 and on the basis of the new 'Risk Assessment Framework', the Trust was rated as green (no evident concerns) for the year.

Indicator	Last Year 2012/13	Target 2013/14	2013/14	Variance	Year
Quality (Safety, Effectiveness & Patient Safety)					
Referral to Treatment waits % completed admitted adjusted pathways seen within 18 weeks[1]	94.41%	90%	91.01%	1.01%	●
Referral to Treatment waits % completed non admitted pathways seen within 18 weeks[1]	99.09%	95%	98.20%	3.20%	●
Referral to Treatment waits % incomplete pathways waiting less than 18 weeks[1]	95.35%	92%	93.75%	1.75%	●
Diagnostic Test waiting times	0.27%	1%	0.36%	-0.64%	●
A&E waiting time – Maximum waiting time of four hours from arrival to admission/ transfer/discharge	95.08%	95%	94.52%	-0.48%	●
All Cancer Two Week Wait	94.98%	93%	94.28%	1.28%	●
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	94.77%	93%	93.33%	0.33%	●
All Cancer 62 day urgent referral to treatment wait	88.93%	85%	85.64%	0.64%	●
62 day wait for first treatment following referral from an NHS Cancer Screening Service	94.23%	90%	100.00%	10.00%	●
31 day standard for cancer diagnosis to first definitive treatment	99.59%	96%	97.80%	1.80%	●
31 day standard for subsequent cancer treatments - surgery	100.00%	94%	99.55%	5.55%	●
31 day standard for subsequent cancer treatments - anti cancer drug regimens	100.00%	98%	100.00%	2.00%	●
MSA breaches	4	0	0	0	●
HCAI - MRSA Bacteraemia[2]	6	0	4	4	●
HCAI - Clostridium Difficile[2]	60	<=36	36	0	●
Friends & Family Test - Response rate[3,4]	NA	20%	23.43%	3.43%	●
Dementia - Find[5]	97.67%	90%	99.15%	9.15%	●
Dementia - Assess & investigate[5]	100.00%	90%	100.00%	10.00%	●
Dementia - Refer[5]	95.51%	90%	99.77%	9.77%	●
VTE risk assessment for inpatient admissions[6]	92.36%	95%	95.36%	0.36%	●
Quality stroke care - people who have a stroke who spend at least 90% of their time in hospital on a stroke unit	88.06%	80%	84.81%	4.81%	●
Quality stroke care - people at high risk of stroke who experience a TIA are assessed and treated within 24 hours	63.56%	60%	76.28%	16.28%	●

[1] Excludes non English commissioners as per publications by NHS England (http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/)

[2] Cases apportioned to Acute Trust

[3] Aggregate inpatient and A&E performance shown for quarter 4 against the national quarter 4 target.

[4] New national CQUIN indicator for 2013/14

[5] New national CQUIN indicator implemented part way through 2012/13 therefore performance shown for 2012/13 is for quarter 4 only

[6] National CQUIN target for VTE risk assessments increased from 90% to 95% for 2013/14

Cancer 62 day urgent referral to treatment wait

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

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

Clostridium difficile infection

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

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

Accident and Emergency

During 2013/14 the Trust continued to receive a high number of patients arriving through the A&E department, both via ambulance and self-presenting. This has affected the Trust's ability to meet the A&E target for patients spending a maximum of 4 hours in the department and unfortunately performance for 2013/14 was under target at 94.5%. Performance has improved in March to 96.3% and many of the initiatives which have been put in place are starting to have a positive impact on the flow of patients through the Emergency Department.

Cancer Waiting Times

The Trust continues to meet all cancer waiting time targets, ensuring patients are seen and treated in line with national standards. Work has commenced with our local Clinical Commissioning Group on streamlining cancer pathways for certain tumour groups and this should lead to further improvements in waiting times for patients.

Reducing Healthcare Associated Infections (HCAIs)

The Trust has made significant improvements in reducing healthcare associated infections from 2012/13 to 2013/14. There have been 4 cases of MRSA bacteraemia which is above the 'zero tolerance' target but is an improved position compared to 6 cases in 2012/13. The Trust has further reduced the number of *Clostridium difficile* infections from 60 in 2012/13 to 36 in 2013/14, which is equal to the target of 36 cases. The Trust has invested in various initiatives during the year which have contributed to the reduction in HCAIs and our associated reduction plan will continue into 2014/15.

Improving Dementia care

In 2013/14 the national CQUIN (Commissioning for Quality and Innovation) scheme for Foundation Trusts continued to include indicators to improve the identification of patients with dementia and ensured that they received necessary support. The CQUIN indicators relate to all patients aged 75 years and over who were admitted as an emergency and stay in hospital for more than 72 hours. The Trust has continually exceeded the national targets relating to these indicators to ensure that where patients are identified as potentially having dementia, they are appropriately assessed and where appropriate referred on to specialist services.

Annex One: Statements from Coordinating Commissioners: NHS Sunderland, NHS Durham Dales, Easington and Sedgefield (DDES) and NHS North Durham Clinical Commissioning Groups (CCGs), and NHS England.

Sunderland, DDES and North Durham CCGs aim 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. NHS Sunderland CCG coordinates commissioning with City Hospitals Sunderland's other main commissioners.

Throughout 2013/14 monthly Quality Review Group (QRG) meetings, with representation from NHS Sunderland CCG and NHS Durham Dales, Easington and Sedgefield CCG (DDES) and NHS England have taken place with City Hospitals Sunderland NHS Foundation Trust (CHSFT). 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. Serious Incident summary report
- review and discuss relevant external reports e.g. Care Quality Commission specific to CHSFT, and national reports e.g. Francis 2, Berwick and Keogh
- monitor action plans arising from the above

NHS Sunderland CCG recognises the good work undertaken in 2013/14 and looks forward to working with you in 2014/15.

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

- a reduction in the numbers of cases of Clostridium Difficile
- increased reporting of near misses and no harm incidents
- improvement in ambulance handover times
- achievement of the national targets for the Friends and Family Test
- continued development of real-time feedback from patients;
- achievement of all cancer targets,
- timeliness and reporting of pressure ulcers
- improvements in length of stay for dementia patients
- reporting and progress made relating to falls within the National Safety Thermometer
- improvements in food service and patients' responses in the national inpatient survey,

The Trust has again experienced significant pressures within the Emergency Department, causing continued difficulties in maintaining the required level of performance against the emergency care performance and the CCGs look forward to continue to work with provider colleagues to deliver action plans developed to improve patients' experience and achieve the national targets during 2014/15.

Although the national trajectory for infection control targets for Clostridium Difficile has increased for 2014/15 there is a mutual expectation that the Trust will maintain its focus to continue to deliver a maximum of 36 cases, which we very much welcome as commissioners and reflects the efforts and focus of the Trust to successfully reduce the incidence in 2013/14.

The CCG acknowledges the initial adverse impact that the implementation of Meditech version 6 had on the Trust and their systems' ability to communicate effectively with GPs and patients. It recognises the efforts that were made to rectify the problems to try to ensure that patient safety was not compromised. Any ongoing issues will require further work between GP practices and the Trust to resolve.

Commissioners look forward to working with the Trust to build on the work in 13/14 to continue to improve the timely closure of Serious Incidents to ensure the appropriate lessons can be learnt and shared accordingly.

The CCGs acknowledge the work being undertaken to review the Breast Surgery pathways which will include joint working arrangements with other local providers to ensure safety and enhance patient experience.

Reducing the number of pressure ulcers continues to be a challenge and the CCG will be working with the Trust and the wider health economy during 2014/15 building on the progress already made.

Commissioners welcome the ongoing work being undertaken by CHSFT to analyse their mortality rates reported nationally and the CCG looks forward to receiving further assurance that patient safety is not being compromised.

Sunderland CCG, DDES CCG, North Durham CCG and NHS England note the changes to the CQC intelligence monitoring profiles and agree with the priorities outlined in the Quality Report for 2014/15 and will work in partnership to achieve the common goals of improving access, experience and patient safety for all patients.

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

Annex One: Statement from Overview and Scrutiny Committee (OSC)

"Thank you for the opportunity to comment on your 2013/14 Quality Report which provides a good account of the performance achieved during the past year.

Scrutiny Councillors in Sunderland have done a significant amount of work this year on patient and public engagement. We therefore welcome the Trust's ambition towards increasing the proportion of patients who feel listened to and involved in their care. We also welcome the emphasis in the Quality Report on the way that patient complaints will be used to improve services. The Clwyd review identified that complaints should be treated like 'gold dust' for decision-makers and we are pleased to see reflected in the Quality Report that a number of actions have been identified to further improve the complaints handling process.

Scrutiny Councillors investigated services dealing with child obesity during the year and discussed diet, nutrition and lifestyle with colleagues from City Hospitals. Scrutiny Members were able to evidence the partnership working that exists around key intervention strategies including the Specialist Childhood Weight Management Service that is integrated within the Sunderland Lifestyle, Activity and Food Programme.

The Trust also cooperated to provide evidence into the Supporting Carers in Sunderland review undertaken during 2013/14. Scrutiny Councillors were pleased to see the positive recognition given by the Trust to employees with a caring role.

Sunderland Scrutiny Councillors wish to endorse the quality priorities for 2014/15 and proposed indicators for improvement as described in the Quality Report. In delivering those ambitions, Scrutiny Councillors in Sunderland look forward to working with the Trust in the year ahead."

Annex Two: Statement of Directors' Responsibilities for the Quality Report

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

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support 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 2013/14;

- 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 2013 to May 2014
    - papers relating to Quality reported to the Board over the period April 2013 to May 2014
    - feedback from the commissioners dated 23 May 2014
    - feedback from governors dated 25 march 2014
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 May 2014
    - 2013 national patient survey 8 April 2014
    - 2013 national staff survey 25 February 2014
    - the head of internal audit's annual opinion over the trust's control environment dated 22 May 2014
    - CQC quality and risk profiles dated May and July 2013
    - CQC intelligent monitoring reports 21st October 2013 and 13th March 2014

- 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) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

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

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

How you can provide feedback on our Quality Report

Production of the Quality Report

We are very grateful to all those who have contributed to the production of this year's Quality Report 2013/14. The Trust welcomes any comments you have about the current Quality Report but also asks you to help shape next years' Quality Report by sharing your views and contacting Corporate Affairs via;

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

Availability of the Quality Report

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

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