City Hospitals Sunderland
NHS Foundation Trust

Quality Report 2016/17

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What is a Quality Report?

The Quality Report (also known as a Quality Account) is an annual report published by providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

What should a quality report look like?

Some parts of the Quality Report are mandatory and are set out in national regulations. The Quality Report includes:

- Part 1 - A statement from the Board summarising the quality of the NHS services provided;
- Part 2 – The organisation's priorities for quality improvement for the coming financial year;
- Part 3 - A series of statements from the Board for which the format and information required is set out in the regulations; and
- Part 4 - A review of the quality of services in our organisation, presented in three domains of quality, patient safety, clinical effectiveness and patient experience.

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.

What does it mean for City Hospitals Sunderland NHS Foundation Trust?

The Quality Report allows NHS healthcare organisations such as City Hospitals Sunderland to demonstrate their commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities and improvement in other quality areas.

What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services in an organisation into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Report is designed to assure patients, members of the public and stakeholders that as an NHS healthcare organisation City Hospitals Sunderland is scrutinising each and every one of its services, particularly focusing on those areas that require the most attention.

How will the Quality Report be published?

In line with legal requirements all NHS Healthcare providers are required to publish their Quality Reports electronically on the NHS Choices website by June 2017. City Hospitals Sunderland NHS Foundation Trust will also make the Quality Report available on its website **www.chsft.nhs.uk**

Part 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Each year I feel compelled to reflect on the testing environment in which the Trust aims to provide first class healthcare services in a safe and compassionate way. The financial challenges affecting the NHS are well documented and the task of finding new ways to become efficient and cost effective without compromising quality and safety are understood by all of us. Last year was no different. However I think we have met whatever challenges came our way in a fairly calm, professional and measured way which bodes well for how we succeed in the future.

Part of that future involves working more closely with our health and social care colleagues. At a regional level the Trust has been collaborating with its partners to develop Sustainability and Transformation Plans which set out an ambitious blueprint for better working across the whole health and social care system. With this in mind, I mentioned in last year's statement that we were on a journey, embarking on a new joint health alliance with South Tyneside Hospital. I'm delighted to say that the alliance is progressing well and moving in the right direction.

We have begun our programme to review clinical services across both Trusts which is led by our clinicians and clinical experts. This will continue in phases until the end of 2017/18, with phase one including Stroke, Trauma and Orthopaedics, Obstetrics and Gynaecology, General Surgery and Paediatrics. Change on this scale will inevitably cause some concern to patients and families who use these services as we work through the detail to create the best model of care for both communities. We are also mindful of the impact on our staff. Our commitment has not wavered in making sure that they are fully involved in the process. Our intention is to get our service profile and plans right from the start.

Whilst needing to address and help shape the future it is also important that we take stock and reflect on what has happened during this busy year and, once again, I believe that we have achieved a great deal across the Trust. The Quality Report will summarise some of the more notable successes, but it cannot possibly reflect them all. There is also an opportunity to set out our quality priorities for next year.

I'm particularly delighted to report that the new £20m redevelopment of our adult Emergency Department is now 'open for business' providing one of the most spacious, modern and technologically advanced units in the Country. We also opened our new Endoscopy Unit in 2016. The redesign ensures that patients are seen in an environment which meets best practice standards for patient flow, quality, safety and experience.

More recently, the Trust has been identified as one of 12 global digital exemplar sites which will allow us to further enhance our fully integrated electronic patient record system to ensure we have an IT system fit for the 21st century.

Another year has seen us achieve the vast majority of our Commissioning for Quality and Innovation (CQUIN) targets. This is an excellent achievement. One of the more challenging areas in the scheme is the management of patients with sepsis. Whilst we were able to show incremental progress in identifying and rapidly treating patients with this life threatening condition during the year, we were unable to reach the challenge of the national targets set. Further details about the work we have done and what we plan to do next year are provided in the section on our quality priorities.

The results from our patient satisfaction surveys show that we are meeting patient and public expectations most of the time. During this year we joined the in-patient Friends & Family Test with our Real Time Feedback questionnaire to create a new 'Patient Experience Survey'. This provides us with a rich resource of feedback and comment on which to identify areas for improvement. We also routinely feedback to wards where patients have told us that we have done well.

At this point it seems only right to acknowledge the contribution of our Community Panel who did so much to raise the profile of patient and public involvement in the Trust over the years. They played a huge part in making real time feedback such a success and gave us valuable information about the experiences of our patients. But after 12 years we decided, with their endorsement, to disband the Panel but made sure that their functions and ability to challenge was taken on by our Trust Governors.

On a related matter, we introduced 'Excellence Reporting' throughout the Trust in February 2017. This is a new system whereby staff report what they have observed as being 'excellent' by a team or individual members of staff. Excellence is whatever staff believe is outstanding, for example great care, superb teamwork, service improvements or staff going the extra mile. Capturing these episodes of excellence helps us to appreciate when things go well and by reflecting on these positive events, we can all learn. It is no surprise that the new system has been well used and we have already exceeded the 100 mark!

Participation in clinical audit is vital in ensuring that patients receive care that meets national standards. We do participate in numerous national clinical audits and the findings suggest that we are providing services that are safe and delivering care that is to a high standard. Where we find any variations in care then we will do our best to make changes to our practices.

We continue to closely monitor and review our mortality performance. We strengthened the governance of our Mortality Review Panel process this year and introduced a new targeted review process for end of life care. Our mortality data shows that we are about the same as other similar organisations, although we did receive a mortality alert for bowel obstruction which we have fully investigated and provided satisfactory evidence to the Care Quality Commission.

It is a given that next year will provide the most challenging environment yet for the NHS. We are doing what we can, with our colleagues and wider partners, to focus on the essentials of care in order to continue to improve clinical outcomes and to ensure that our patients have a positive care experience.

We remain, as always, grateful for the ongoing commitment and contribution of patients, staff, governors, members, commissioners and other stakeholders in supporting our quality improvement activities and providing the oversight, scrutiny and constructive challenge that are essential to improving the quality of our services.

The content of this report has been subject to internal review and, where appropriate, to external verification. I confirm, therefore, that to the best of my knowledge and belief, the information contained within this report reflects a true, accurate and balanced picture of our performance.

KEN BREMNER
Chief Executive Date: May 2017

PART 2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Last year the Trust identified four quality priorities for improvement 2016/17. This section of the Quality Report shows how the Trust has performed against each of these priorities. In addition, there are a number of indicators of improvement that we have selected and these are described in more detail in Part 3.

	Priority	Objective	Rating
Patient Safety	Reduce the number of hospital acquired pressure ulcers	Reduce avoidable category 2-4 hospital acquired pressure ulcers by 25%	Fully achieved
Clinical Effectiveness	Review Trust mortality and minimise avoidable deaths	a) To review > = 80% of patient deaths using the Mortality Review Panel process	Mainly achieved
		b) To achieve > = 90% of responses for requests for specialty mortality reviews	Fully achieved
		c) Full participation in the national mortality case record review programme	Not applicable
Patient Experience	Improve the in-hospital management of patients with dementia	Implement the priorities from the national audit of dementia care in general hospitals	Fully achieved
Staff Experience	Increase the number of staff participating in the staff Friends & Family Test	20% improvement in staff participation on the 2015/16 total responses	Fully achieved

2.1 Review of Priorities for Improvement 2016/17

Each year, we work with our staff, healthcare partners and local stakeholders to agree a number of areas for improvement. These priorities provide our focus for raising standards and improving quality for the coming year and we have put plans in place to continually review and report the progress we are making. Each section summarises the priorities we set for 2016/17; this is followed by a detailed account of our progress and achievements.

Patient Safety

1. Reduce the number of hospital acquired pressure ulcers (HAPU)

Lead Contact: Debbie Cheetham – Lead Nurse Patient Safety

Target: Reduce avoidable category 2-4 HAPU by 25% in 2016/17 (and over the following 2 years)

Pressure ulcers represent a major burden to the patient and to the NHS; they can have a life changing and devastating impact on patients and their families. They are often associated with an increased risk of secondary infection and are a major cause of morbidity, especially in older people. They are categorised from one to four according to the level of severity, with four being the worst, characterised by a deep, penetrating ulcer. However, even with the highest standards of care it is not always possible to prevent pressure ulcers in particularly vulnerable patients.

Over the last 3 years the Trust has consistently appeared to be an outlier for HAPUs, with a higher incidence than that reported by other Trusts via the national 'Open & Honest' programme. We no longer benchmark our performance against other Trusts using this approach as an increasing number of hospitals have decided to opt out of the programme. However, the same data is collected, validated, internally reported and continues to inform Ward Dashboards on the Trust's Data Information Launchpad.

The Trust's Tissue Viability Steering Group (TVSG) is leading on this quality priority. The purpose of the group is to promote patient safety and harm free care, by making improvements in the prevention and management of pressure ulcers. In June 2016 we initiated a Trust-wide Pressure Ulcer Improvement Plan (2016-2019). This plan outlines the strategies and measures we will put in place to reduce the incidence of hospital acquired pressure ulcers. The improvement goal is a 25% per annum reduction in avoidable category 2-4 HAPUs over the next 3 years. Using the metric of 'rate per 1,000 occupied bed days', this will amount to a gradual reduction from 2.33 (City Hospitals 2015-2016 average) to 0.98. The Trust's Ward Dashboard is being used to map these improvements, in addition to data from another national programme called the 'Safety Thermometer' (provides a 'temperature check' on harm) and ward based audits.

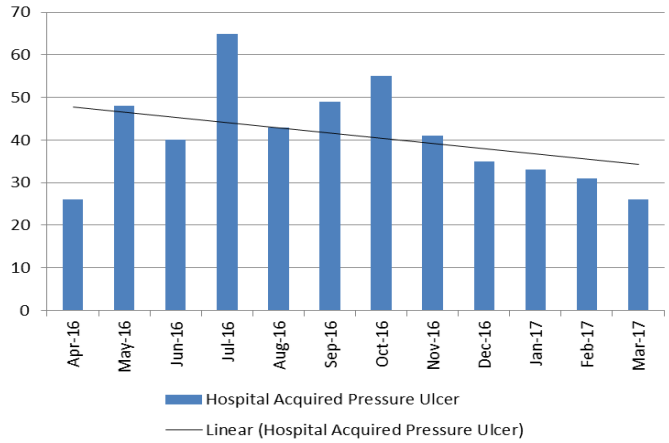
Summary of performance 2016/17

At the end of the first year of the improvement plan, the March 2017 figure shows that Trust performance has culminated in an end of year position of 1.41 HAPUs per 1,000 bed days which is significantly below the improvement trajectory of 1.75 for the first year of the 3 year plan. This March figure represents a 39% reduction in the rate of HAPUs from the 2015/2016 baseline (2.33), surpassing the improvement target of 25% for 2016/2017.

A detailed breakdown of the categories of HAPUs for 2016/17 from the Ward Dashboard data is shown below:

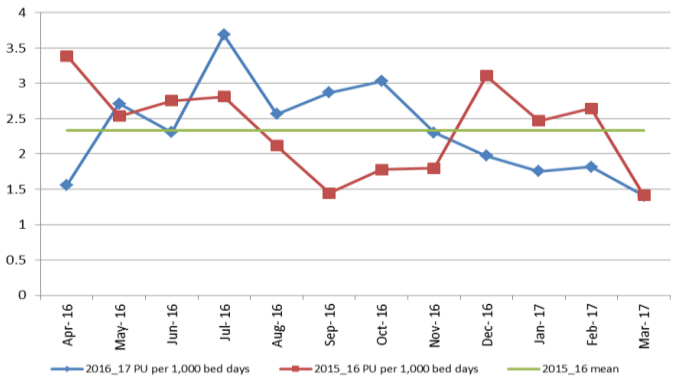
HAPUs	April 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Category 2	24	48	38	63	39	45	51	40	35	32	29	25
Category 3	2	0	0	1	3	3	2	0	0	1	0	0
Category 4	0	0	2	1	1	1	2	1	0	0	2	1
Total	26	48	40	65	43	49	55	41	35	33	31	26
Rate per 1,000 bed days	1.56	2.71	2.31	3.69	2.56	2.87	3.03	2.30	1.97	1.75	1.81	1.41

When the data is plotted on a bar chart (below) the downward trend line clearly shows the reduction of HAPUs, particular over the second 6 months period.



Number of hospital acquired pressure ulcers (Ward dashboard April 16 – March 17)

City Hospitals HAPU: actual performance 2015/16 V 2016/17 per 1,00 bed days (Ward dashboard)

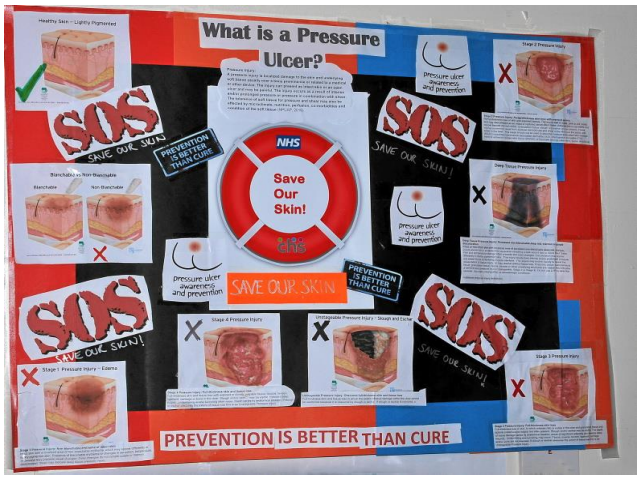


It is not appropriate to compare the average figure over this year to the previous year, as the new initiatives associated with the improvement plan did not commence until Q2. The improvement plan is an incremental journey and a judgement on the performance over the year is based on the end of year position relative to the improvement trajectory, which clearly demonstrates that we are below where we aimed to be. However, whilst comparing 2015/16 and 2016/17 HAPU (above right), it is noted that during 2016/17 there were 7 months where performance was the same as or better than the 2015/16 average and of these 5 consecutive months were during winter pressures (November 16 – March 17).

What did we do in 2016/17?

- introduced Health Care Assistant Pressure Ulcer Champions in wards to help compliance with the "SSKIN Bundle" (five steps or interventions known to prevent pressure ulcers and /or their deterioration);
- established a Pressure Ulcer Review Panel to provide the opportunity for a deep dive into the care and management of patients who develop category 3-4 HAPUs so we can learn any lessons;
- hosted a Pressure Ulcer World Café to help generate a network of people to generate and support ideas and ways to improve pressure ulcer prevention and management; and
- Introduced monthly Matron audits of "SSKIN Bundle" which will be rolled out across the Trust.

Furthermore, In November 2016 we celebrated 'International STOP Pressure Ulcer Day' with our wards once engaged in a range of activities to raise awareness among staff, patients and visitors about the prevention of pressure ulcers. Some of the posters used to promote the day are shown below:



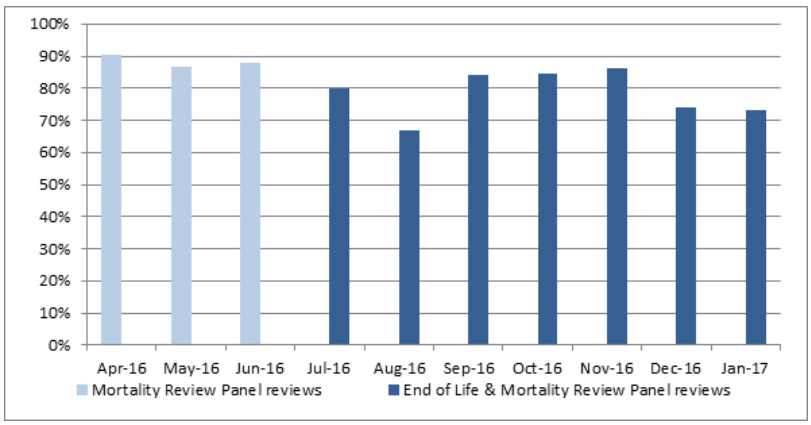
Clinical Effectiveness

	1. Review Trust mortality and minimise avoidable deaths
Lead Contact(s):	Mr Ian Martin – Medical Director Dr David Laws – Consultant Anaesthetist and Chair Mortality Review Panel Gary Schuster – Clinical Governance Manager
Targets:	a) To review > = 80% of patient deaths using the Mortality Review Panel process b) To achieve > = 90% of responses for requests for specialty mortality reviews c) Full participation in the national mortality case record review programme

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. The Trust has a well-established Mortality Review Group (MRG) to monitor and review Trust performance with all the national mortality indicators. We also have a weekly Mortality Review Panel (MRP) to review the care of patients who have died so that we can identify and address any problems in care. However, many deaths in hospital will be a natural terminal event despite medical advances and excellence in care.

a) To review > = 80% of patient deaths using the Mortality Review Panel process.

The Mortality Review Panel (MRP) is a weekly meeting of senior doctors and other clinical staff who critically review all in-hospital deaths. The meeting excludes consideration of child and maternal deaths as they already have their own statutory process. At the conclusion of each case review, the MRP provides a judgement on the preventability of death and whether there are improvements required in any clinical or organisational aspects of care. Some patient deaths are referred for specialty review and opinion regarding any problems or unexplained variability in care. Monthly reports on outcomes from the MRP are presented to Clinical Governance Steering Group and summarised for Governance Committee and the Board of Directors.



Last year we were able to report that the MRP had been able to consistently review a high proportion of in-hospital deaths. In fact, our performance was one of the highest in the region among our peer Trusts. The chart shows the percentage of deaths reviewed by the MRP during 2016/17 where we were able to meet and exceed the target set most of the time.

It is worth noting that in July 2016 the MRP process changed to incorporate a separate end of life care review. In this process all patients who had received either specialist palliative care or general end of life care were subject to a structured review enabling the Trust to assess the quality of end of life care given. The review looks at the five priorities of care for the last few days or hours of a person's life. The specific end of life and general MRP reviews provide important information about the care and treatment patients receive whilst in our care so that we can learn any important lessons. There are also monthly and quarterly reports to the Board regarding the outcomes from our mortality reviews. In 2017, there will be new responsibilities placed on the NHS regarding how hospitals investigate, report (to the public) and learn from deaths. We are well positioned to meet these expectations.

b) To achieve >=90% of responses for requests for specialty mortality reviews.

During the initial screening of deaths, where any potential concerns with clinical and / or organisational care are identified by the MRP a more detailed specialty review is requested and the clinical team is asked to comment on the the Panel's findings. Where the specialty agrees with the comments they are required to set out what actions they feel are needed to address the issues. To date, clinical engagement with the MRP process has been excellent and during 2016/17 we exceeded the target set and achieved 100% of requests for specialty mortality reviews. The responses and actions from the specialty review are included in monthly MRP summaries for assurance.

The process of specialty reviews and the engagement from clinical staff has led to improvements in both clinical and organisational care. Some of the more notable improvements include; more frequent discussions about resuscitation status with patients and families and agreeing 'ceilings of care', better recognition and clinical management of sepsis, the availability of specialty induction programmes and more accurate and contemporaneous clinical documentation.

c) Full participation in the national mortality case record review programme.

The NHS anticipated the introduction of the new national mortality case record review programme during 2016/17. This did not happen as expected. Whilst initial guidance on the methodology has been published by the Royal College of Physicians (who are leading the programme) the first phase of the national programme rollout has not taken place. Having discussed the guidance internally and with colleagues via the North East Regional Mortality Group the Trust will be well placed to incorporate the standardised approach when introduced nationally. In addition, we are delighted to report that the Chair of the Trust Mortality Review Group has been selected as a regional trainer in the new methodology.

What are the plans for 2017/18?

Two important reports were published in 2016/17 which will guide our mortality work in 2017/18. The first was published by the CQC 'Learning, Candour and Accountability' (http://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf) and reviewed the way NHS Trusts review, investigate and learn from patient deaths. The second is partly in response to the recommendations from the CQC report. 'National Guidance on Learning from Death' (https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf) was published by the National Quality Board and provides a standardised framework for Trusts to implement improvements in how they review and learn lessons following death. There is a strong focus on including families and carers in the investigative process. We have already had an initial discussion with the Board about how the new arrangements will impact on the Trust. We will also continue to work with our peers in the Regional Mortality Group to ensure a consistent approach among all local hospitals.

In addition, and in response to the new national requirements, we will also;

- review and revise the Trust Mortality Review Panel process and enhance our existing mortality governance arrangements;
- embed mortality review processes for some of our most vulnerable groups, i.e. those with learning disability, patients with mental health issues;
- provide training and support for clinicians involved in the investigative process;
- collect and publish quarterly mortality data and information on the outcomes of actions taken by the Trust following patient deaths; and
- develop a policy for the engagement of families in the process of investigating death (if they wish to do so) and provide genuine and compassionate support throughout.

Patient Experience

1. Improve the in-hospital management of patients with dementia

Lead Contact(s): Julie McDonald – Deputy Director of Nursing & Patient Experience (Corporate Lead)
Dr Lesley Young – Consultant and Clinical Dementia Lead

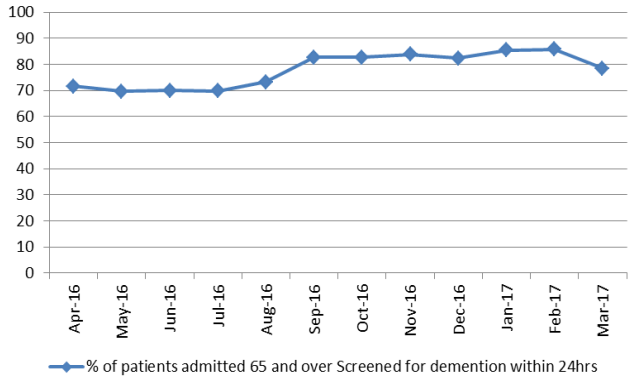
Target: Implement the priorities from the national audit of dementia care in general hospitals

Evidence shows that a significant proportion of general hospital in-patients are people with dementia. What happens in general hospitals can have a profound and permanent effect on individuals with dementia and their families, not only in terms of their in-patient experience, but also their ongoing functioning, relationships, wellbeing and the decisions that are made about their future. In addition, the pace in acute hospitals places high demands on staff and, in these environments, their priority is focused on monitoring and managing the acute needs of patients which can sometimes compromise the extended time required for dementia patients. City Hospitals has participated in the National Audit of Dementia Care in General Hospitals since it started in 2010. The national report highlights some problems in the care received by people with dementia whilst in hospital. We have an action plan and a well-established Dementia Steering Group which oversees and drives improvements in the care for dementia patients, including the creation of dementia friendly environments. The targets identified for this priority have been informed by key areas within our action plan.

Increase the Identification and Assessment of Patients with Dementia

In 2012, the Department of Health required all hospitals to assess people aged 75 years and over, admitted urgently, for the possibility of dementia. The Trust achieved this target throughout 2015/16. This assessment was expanded in 2016/17 to include all patients aged 65 years and over, to ensure compliance with NICE guidelines. This has required significant education of relevant staff and changes made to electronic documentation. In addition, ward level performance against the target has been included on ward dashboards.

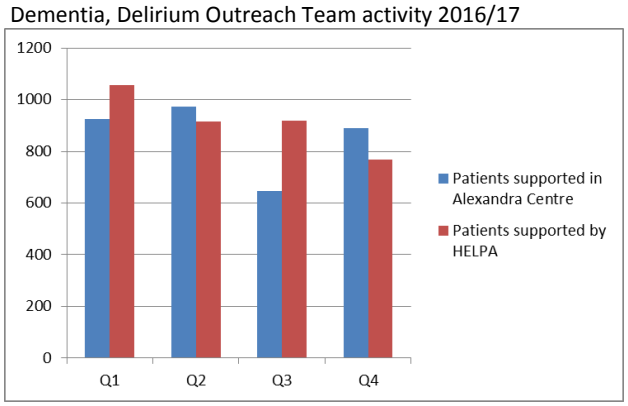
% of patients admitted 65+ screened for dementia within 24 hrs



The chart shows a steady trajectory of improvement in the number of patients (65 years and over) admitted to hospital, who were screened for dementia within 24 hours. In February 2017, 86% of patients were screened, compared to 72% in April 2016.

Increase the number of patients seen by the Dementia, Delirium Outreach Team (DDOT)

Dementia, Delirium Outreach Team activity 2016/17



DDOT support better recognition of, and care for, patients with dementia and/or delirium by outreaching onto wards.

In addition, patients who are well enough can attend the Alexandra Dementia Centre, to receive therapy. For those not able to attend, Hospital Elder Life Programme Assistants (HELPAs) will visit patients on wards to provide support and therapy, such as reorientation and cognitive stimulation therapies, and ensure that any sensory deprivation is addressed e.g. ensuring that hearing aids are working and offer support with hydration.

Improve Carer Involvement with Dementia Patients

Whilst actions to improve involvement of carers are not limited to carers of patients with dementia, it is recognised that most patients with dementia have friends and family members that provide support, although often they do not identify themselves as carers. Our work has focused on identifying carers and empowering them to be as involved in the patient's care as much or as little as they would like.

The Carers' Charter

The Carers' Charter was implemented in 2013 and continues to be displayed in all wards and departments as part of our ongoing initiatives to raise awareness and improve the experience of carers. This is further supported by a more detailed "Caring for Carers" algorithm or pathway. The Carers' Charter has been updated and reprinted in a larger A3 format to ensure visibility for staff, patients and carers.

The key messages for City Hospitals staff are to:

- identify carers early;
- signpost and provide information about Sunderland Carers' Centre; and
- involve carers in delivery and discussions about the patient's care (as appropriate)

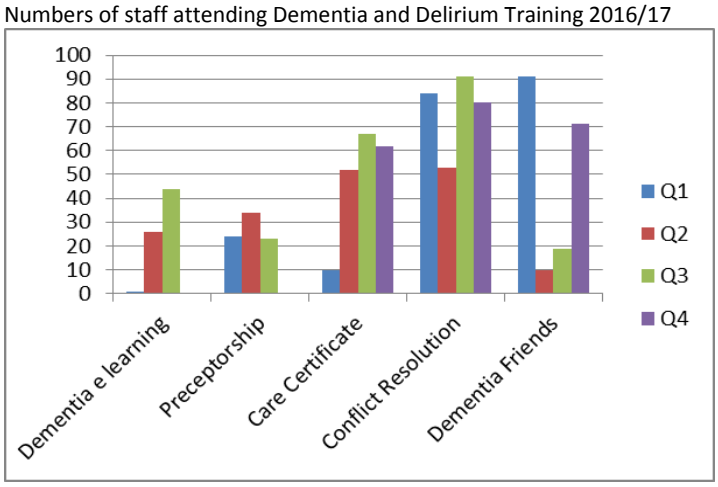
John's Campaign and Carer's Passport

John's Campaign is a national campaign, which seeks to increase the number of hospitals where carers of people with dementia are welcome to continue supporting the person they care for outside regular visiting hours and, in some instances, 24 hours a day if they wish to do so.

City Hospitals were one of the first Trusts nationally to pledge support to deliver this campaign, and have actively promoted this during 2016/17, through the carer's passport. The passport encourages carers to "have a conversation" with staff about their caring role and their needs, to ask about visiting outside of normal hours and staying overnight if appropriate.

Monitor the numbers of staff who receive dementia awareness training

Numbers of staff attending Dementia and Delirium Training 2016/17



Dementia training underpins the delivery of high quality dementia care, and is key to the delivery of the Dementia Action Plan. Training is included in staff induction and has been incorporated into a number of existing Trust-wide courses. In previous years, much of the training has been delivered locally and it has been difficult to quantify with any certainty how many staff have attended. Baseline data has been collected in 2016/17 and this will be used to inform 2017/18 targets. The chart opposite shows the number of staff attending dementia and delirium training delivered during 2016/17. In addition 92 staff attended the Annual Safeguarding Symposium which included sessions on mental capacity and deprivation of liberty.

During 2016/17 a new e-learning package has been developed and is currently being rolled out for clinical and non-clinical staff. This training maps to Tier 1 of the National Dementia Core Skills Education and Training Framework.

Dementia Friendly Environments

Hospital stays can have a detrimental effect on people with dementia and evidence suggests that relatively straightforward and inexpensive changes to the design and fabric of the care environment can have a considerable impact on the well-being of people with dementia. The University of Stirling (Design for People with Dementia) have developed an audit tool to provide a framework for assessing existing environments for people with dementia, and these principles have been incorporated into the national PLACE inspection tool.

Dementia environment standards to inform all refurbishment and new build work

Dementia friendly environment standards for in-patient areas were ratified in February 2017, with Trust-wide agreement that these will inform any future work, recognising there is no additional budget for this.

Work has already started to improve hospital and ward based signage, which will include pictures and an example is included below. Toilet seats are being replaced and handrails painted with contrasting colours, in care of the elderly wards, to make them stand out.

Install orientation boards and clocks

It is well recognised that people with dementia are likely to become agitated in unfamiliar surroundings and providing visual clues and prompts, to help them orientate, is particularly important.

Providing visual access to clocks and signs indicating the name/type of department helps with orientation. Orientation boards, purchased from charitable funds, have been installed in all adult in-patient wards and large faced clocks are currently being purchased.

Plans for 2017/18, will include the alignment of practices for patients with dementia across the South Tyneside and Sunderland Healthcare Group. Priorities for improvement include:

- embedding the use of “This is Me” document - “This is Me” or Patient Passports are completed by the patient (if able) and their family members, and include personal information such as likes and dislikes, occupation and family information. This helps the staff to get to know the patient on a personal level. Whilst this documentation is already available its use is not consistent throughout the Trust, and this will be reinforced in 2017/18; and
- development of Enhanced Care Guidance - management of behavioural disturbances such as confusion, and memory problems as a result of delirium or dementia can stop patients from remembering to keep themselves safe, resulting in for example an increased risk of falls. It can be extremely challenging to prioritise patient care in relation to those patients that require additional observation. In such instances, risk management strategies must be used and an enhanced level of continuous observation may become necessary. A Standard Operational Procedure will be developed to assist staff in delivering the least distressing, compassionate and safe level of care to our patients.

Staff Experience

1. Increase the number of staff participating in the staff Friends & Family Test (FFT)

Lead Contact: Julie McDonald – Deputy Director of Nursing & Quality

Target: Increase the number of staff participating in staff FFT – 20% improvement on 2015/16 total responses

From April 2014 all staff have had the opportunity to feed back their views on working in City Hospitals at least once per year. The aim is to help promote a big cultural shift in the NHS where the experiences of staff are increasingly being sought, heard and are acted upon. We want to increase the number of staff who engage in the survey and furthermore to utilise any additional comments so that we can target our actions to improve the workplace and achieve a better work-life balance.

Evidence has shown that the extent to which staff would recommend their Trust as a place to work or receive treatment shows a high correlation with patient satisfaction. Therefore listening to the experiences of staff is also important for improving the patient experience. The Staff FFT consists of two questions through which organisations can take a 'temperature check' of how staff are feeling, by asking:

- how likely are you to recommend City Hospitals Sunderland to friends and family if they needed care or treatment?
- how likely are you to recommend City Hospitals Sunderland to friends and family as a place to work?

Participants respond to FFT using a response scale, ranging from "extremely unlikely" to "extremely likely". In addition, the survey asks staff to provide comments on why they chose their answer to help the hospital to identify what it is getting right and where it can improve. Trust level results for each quarter are published nationally on NHS choices which allows for benchmarking performance, but this should be interpreted with caution as Trusts do not always apply the guidance in a consistent way, e.g. some Trusts survey only a sample of staff each quarter, and there is evidence of high scores with very low response rates.

Data for the two mandated questions is highlighted below;

	Quarter 1		Quarter 2		Quarter 3*		Quarter 4	
Staff Friends & Family Test Question	**Trust rate**	**National Average**	**Trust rate**	**National Average**	**Trust rate**	**National Average**	**Trust rate**	**National Average**
How likely would staff be to **recommend** their organisation to friends and family as a place to work (*Number of staff responses - acute*)	73% (864)	66%	69% (976)	66%	Annual staff survey	Annual staff survey	69% (765)	Not available
How likely would staff be to **recommend** the Trust as a place for their friends and family to receive care and treatment (*Number of staff responses - acute*)	83% (864)	82%	82% (976)	82%			83% (765)	Not available
	Total to date: 2605							

* No survey is undertaken in Quarter 3 as it coincides with the annual NHS Staff Survey

Responses have remained consistent throughout 2016/17 and the number of staff participating in Staff FFT was 2605, a 40% improvement on the 2015/16 total, which far exceeds the 20% target set at the beginning of the year.

The results from Staff FFT have been used to understand staff experience and appropriate actions have been taken as a result. For example, staff did report difficulties in maintaining agreed staffing levels on certain shifts in some of our wards. In order to explain what measures the Trust was taking to recruit and retain nurses, against the background of a national nursing shortage, we delivered a series of 'You Said/We Did' communications, face to face discussions, attendance at staff meetings and development of a YouTube video https://www.youtube.com/watch?v=H3iwgyjITGk.

In addition, to further assist the increase in response rates, we have used a variety of promotional measures to encourage staff to complete the survey through team brief, social media (including twitter), posters and screen savers. We will continue to explore these and other options throughout 2017/18.

Priorities for quality improvement 2017/18

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 for the forthcoming year, we have reviewed and reflected upon our performance in 2016/17, which has included the following national and local information sources:

- Trust strategic objectives and service development plans, i.e. annual planning framework; outcomes from the Care Quality Commission Quality inspections;
- feedback from external reviews of Trust services, i.e. Reports from the Care Quality Commission, national clinical audits and registries, Commissioner intelligence etc;
- clinical Benchmarking data and outcomes of Internal Assurance reviews;
- patient safety issues from the Trust incident reporting system;
- participation in national initiatives and campaigns, i.e. 'Sign up to Safety';
- 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 Report.

Our approach this year to selecting our quality priorities has been influenced by Sustainability and Transformation Plans (STP). These STPs set out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the national Five Year Forward View vision. This requires us to work with our partners to make changes to how we access and deliver care and to do things more efficiently.

We were asked to state our quality priorities within the context of our contribution to the STP. The compressed national timetable had the effect of reducing some of the time available to consult with stakeholders. Nonetheless we were able to discuss our priorities with senior managers, (i.e. Corporate Management Team, Executive Committee), a range of clinical professionals, (i.e. Clinical Governance Steering Group) and with our Council of Governors. There was broad agreement that we would carry forward all our quality priorities under the required quality themes for the next 2 years, i.e. 2017/18 and 2018/19. We also agreed that if we felt we had achieved a priority earlier than planned we could 'retire' and replace it with an issue that we felt needed a higher profile. This would help create a more dynamic process that responded to quality issues as they emerged.

For 2017/18, we have revisited each of our quality priorities and proposed indicators for improvement and outlined how each will be measured, monitored and reported. For each priority or indicator a group has been given responsibility to set realistic but challenging targets and highlight key actions necessary. This network of groups will provide an important mechanism for regular monitoring, review and reporting to key internal governance groups. A summary of progress on performance will be presented to the Governance Committee, which is a formal sub-committee of the Board of Directors.

	Patient safety	Measured by	Monitored by	Reporting to
	Priorities for improvement			
1	Reduce the number of hospital acquired pressure ulcers	Ward Dashboard data	Tissue Viability Steering Group	Clinical Governance Steering Group
	Reason why we chose this priority The Trust has prioritised this area of practice for a number of years and has achieved some success in reducing hospital acquired pressure ulcers and their progression to more disabling ulcers. As has already been stated the Trust has embarked on a 3-year improvement plan to reduce category 2-4 hospital acquired pressure ulcers by 25% each year for the duration of the plan. The following initiatives, which have already started in the Trust, will be integral to the Trust achieving its annual target reductions; • implementation and compliance with the SSKIN care bundle; • roll out of the Matron-led SSKIN Bundle audits;			

- sharing the learning outcomes from the Pressure Ulcer Review Panel; and
- participation in the North East & North Cumbria Pressure Ulcer Reduction Collaborative.

Retaining pressure ulcers as a Trust quality priority will continue to enhance its profile among all those who are involved in their prevention and management.

Indicators for improvement

1	Improve the completion, documentation and visibility of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders across the organisation	Internal reporting and audit	Resuscitation Group	Clinical Governance Steering Group

Reason why we chose this indicator

Healthcare professionals are aware that decisions about whether or not CPR will be attempted raise very sensitive and potentially distressing issues for patients and those emotionally close to them. In 2016, the guidance on CPR decision-making for professional staff was revised and these new recommendations have been incorporated into our own guidance for staff which confirms that patients, who are not to be resuscitated in the event of a cardiopulmonary arrest, are clearly identified and that the decision is documented and communicated to all staff directly involved with that patient's care. The decision should also involve and be communicated to the patient's family and carers.

Whilst we have been able to report some improvements in the completion and communication of DNACPR orders in 2016/17, the outcomes from our end of life clinical reviews continue to show that we need to scale up that progress. The target for 2017/18 will be a 10% improvement in DNACPR documentation based on delivery of an agreed action plan. Getting the process right for these decisions is critically important to prevent inappropriate, undignified and futile attempts at CPR which may cause significant distress to patients and their families.

2	Improve the reporting and investigation of hospital associated VTE events	Internal reporting and audit	Venous Thromboembolism Group	Clinical Governance Steering Group

Reason why we chose this indicator

During 2016/17, the Trust Venous Thromboembolism Group introduced a new clinically-led process for reviewing all confirmed case of thrombosis occurring during hospital admission or within 90 days of discharge from hospital. The process will continue to develop in 2017/18 with the following;

- raising the profile of the clinical review process and securing widespread clinical engagement from all relevant specialties;
- refining the reporting format to the internal VTE Group and for our Commissioners; and
- maximising and strengthening learning opportunities when the outcome from reviews shows that certain preventative measures could have been put in place.

3	Reduce the number of patient falls that result in serious harm	Incident reporting system	Falls Reduction Group	Clinical Governance Steering Group

Reason why we chose this indicator

We know that patients fall whilst they are in our care and a small number do suffer harm as a consequence. This tends to be the most common harm that is reported by NHS Trusts. We have identified this as a priority for a number of years and have reported many developments and achievements into how we assess and manage those patients most vulnerable to falling. We know that we require a wholesale cultural change to embed many of the elements of how we effectively prevent and manage falls, and this takes time. For 2017/18 our target will be to maintain our position of being below the regional and national averages for patients suffering harm from a fall in hospital.

	Clinical effectiveness	Measured by	Monitored by	Reporting to
	Priorities for improvement			
1	Review Trust mortality and minimise avoidable deaths	Outcomes from the Mortality Review Panel	Mortality Review Group	Clinical Governance Steering Group

Reason why we chose this priority

The national picture is changing quickly with regard to how hospitals investigate and learn from the care provided to patients who die. April 2017 coincided with new requirements for Trusts to review and strengthen how they involve and support families and carers in investigations following death. The arrangements also require the collection and public reporting of patient deaths, including those that are assessed as having been more likely than not to have been caused by problems in care. It goes on to state that organisations must also publish evidence of learning and action as a result of any problems in care.

The targets for our mortality priority will therefore reflect the direction of travel of the new national agenda aimed at improving learning opportunities from death, and will include;

- strengthening the internal Mortality Review Panel process so that it is able to meet the new national requirements of learning from death;
- publishing quarterly 'dashboard' information on deaths, including estimates of how many deaths were thought more likely than not to have been related to problems in care; and
- public reporting of the impact of actions that the Trust has taken as a result of the review process.

The implementation of the new arrangements will be overseen by the Trust Mortality Group. In addition, City Hospitals will continue to play its part in the Regional Mortality Collaborative.

	Indicators for improvement			
1	Improve the process of fluid management and documentation	Local assurance audit	Nutrition Group	Clinical Governance Steering Group

Reason why we chose this indicator

Our internal audits and staff observations continue to show that the standard of some of our fluid balance recordings could be improved. There remain ongoing issues of data completeness and accuracy within some charts on wards and evidence that trends which give cause for concern are not escalated appropriately. Against this background of variability in practice, the Trust Nutrition Group will continue to raise awareness and drive improvements, such as the introduction of the new fluid monitoring chart.

2	Improve the assessment and management of patients with sepsis	National Unify reporting system	Sepsis Group	Clinical Governance Steering Group

Reason why we chose this indicator

The Government has made a firm commitment to improving the assessment and management of patients who have the potentially life threatening infection known as sepsis. The national campaign to raise awareness among healthcare professionals and the general public alike has gained wide exposure and momentum. The improvements in sepsis care will continue to be an integral part of our national quality scheme (CQUIN) for the next 2 years. New national guidance from the National Institute of Health & Clinical Excellence (NICE) published last year provides the evidence source for making sure we give the right care to those who need it most.

We know that poor initial assessment and delays in treatment can have a major negative impact on patients and can contribute to potentially high mortality. The aim of the national campaign is to develop and implement protocols for screening for sepsis within emergency departments, medical and surgical admission units and in-patient wards. This includes adults and children where sepsis screening is deemed clinically appropriate. The focus is then to ensure that intravenous antibiotic treatment is initiated quickly in those with the most severe forms of sepsis.

The targets set for 2017/18 within the CQUIN scheme are challenging but we will continue to work hard to ensure that patients with sepsis are appropriately assessed and given treatment in a timely way. The targets to

	achieve next year apply both to adult and paediatric Emergency Departments and in-patient ward areas and include the following: • timely identification of sepsis - greater than or equal to 50% (partial achievement), greater than or equal to 90% (full achievement); • timely treatment for sepsis (rapid administration of antibiotics) – greater than or equal to 50% (partial achievement), greater than or equal to 90% (full achievement); and • antibiotic review – quarter 1 (25%), quarter 2 (50%), quarter 3 (75%) and quarter 4 (90%). Performance monitoring and assessing the impact of Trust sepsis initiatives will continue to be overseen by the Trust Sepsis Group.			
3	Reduction in the number of avoidable (predictable) cardiac arrests	National Cardiac Arrest Audit	Resuscitation Group	Clinical Governance Steering Group
	Reason why we chose this indicator We have previously reported that nationally two thirds of all cardiac arrests are predictable events. Often these happen because of a failure to assess, recognise and respond adequately to those patients whose condition deteriorates. Timely response and intervention by the clinical team can prevent cardiac arrest and improve outcomes for patients. The drive therefore is to prevent cardiac arrests through appropriate management of acutely ill people to maximise their chance of recovery. We only partially achieved our target reduction in 2016/17 from data published in the National Cardiac Arrest Audit. We will continue to use this information source as we seek further reductions next year.			

	Patient Experience	Measured by	Monitored by	Reporting to
	Priorities for improvement			
1	Improve the in-hospital management of patients with dementia and collaborate on integrated pathways	Local action plan	Dementia Group	Patient, Carer and Public Experience Committee
	Reason why we chose this priority Hospitals can be overwhelming places for patients with dementia. There is now strong evidence to suggest that creating dementia-friendly environments can help mitigate against the deleterious effects of coming into an acute hospital. However, becoming a dementia friendly hospital requires huge commitment, focus, time and energy to succeed. Nationally, different hospital Trusts are at different stages on the journey to becoming dementia friendly and at City Hospitals we want to be at the forefront of this movement. The National Audit of Dementia Care in General Hospitals assesses the extent to which acute hospitals meet certain standards relating to the care delivery for people admitted with dementia. We have contributed to the audit since its inception and now have a clear understanding about what the problems are and what solutions are needed for supporting this frail and vulnerable group. Making changes to the physical environment and re-designing processes of care will of course take time but we are totally committed to the ambition. Once again, the scope of improvements will be guided and overseen by our Dementia Group.			
	Indicators for improvement			
1	Reducing cancellations of outpatient consultations	Internal performance data	Service Improvement / Performance	Operations Committee
	Reason why we chose this indicator This area of improvement has been previously highlighted by our Council of Governors and has been discussed regularly at their Governor meetings. The unexpected cancellation of outpatient appointments has a profound effect on a patient's experience. Patient feedback continues to show that they remain deeply concerned and dissatisfied about the issue and the potential reputational impact for the organisation could therefore be considerable. There continues to be significant work undertaken throughout the Trust to reduce the number of			

	cancelled outpatient consultations.			
2	Improve the timeliness of responses to patient complaints	Internal performance data	Directorates Help & Advice Service	Patient, Carer and Public Experience Committee
	Reason why we chose this indicator City Hospitals provides a comprehensive range of services for thousands of people every day and we know we get it right most of the time. But sometimes things do go wrong and when this happens and patients tell us about it, how we respond determines whether confidence and trust in the service has been restored. A key part of the complaints process is the timeliness of response to patients and their families. The Trust has taken steps, and had some success, in improving the turnaround times for providing formal complaint responses. We know we need to continue with that improvement, including a commitment to learning from mistakes and show evidence in an open way of what we have done.			
3	Increase the percentage of inpatients who rated their care at City Hospitals as excellent, very good or good (Adult In-Patient Survey)	National Adult In-Patient Survey	Patient Experience / Clinical Governance	Patient, Carer and Public Experience Committee
	Reason why we chose this indicator The survey of adult inpatients is now well established in the NHS and remains one of the biggest surveys of its kind. The survey will move into its 14th year in 2017/18 and our participation enables the Trust to understand more about the patient experience whilst in hospital and to identify areas where we can make further improvements. As an organisation we examine the survey results carefully with other information collected and reported to make changes to our care and services. Collecting feedback by itself has no value. It needs to be used by staff to identify areas that need to be improved through deliberate actions. This final question from the national survey enables patients to give an overall rating of their stay in hospital. We want to increase the percentage of patients who rate their care at the Trust as excellent, very good or good so that we achieve one of the highest composite scores in the North East.			

	Staff Experience	Measured by	Monitored by	Reporting to
	Priorities for improvement			
1	Increase the number of staff participating in the Staff Friends & Family Test (FFT)	Staff Friends & Family Test scores	Nursing & Quality	Patient, Carer and Public Experience Committee
	Reason why we chose this priority All our staff continue to have the opportunity to feed back their views on the Trust at least once per year. This feedback is different to the annual NHS staff survey in that it is designed to complement the survey and give a more up-to-date picture of staff experience. It is also a quick method of feedback, which is easy for staff to complete and the results are available much quicker than the staff survey. In addition It also allows the Trust to respond swiftly and act on the results within a short period of time. Last year we reported a higher proportion of staff completing the Staff FFT. We want this trend to continue particularly at a time when the organisation is going through substantial change and transformation. The Staff FFT will give us an important 'temperature check' on how we are managing the transition and how well we are involving our greatest asset.			

Part 2.2 Statements of assurance from the Board of Directors

Review of services

During 2016/17 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 health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by City Hospitals Sunderland for 2016/17.

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 outcomes data, information from our CHKS clinical benchmarking system, the results of national audits and external inspections, data from the NRLS, complaints, inquests and information from the Parliamentary and Health Service Ombudsman, the Trust Assurance Programme and patient experience data such as the Friends and Family Test and the Patient Experience Survey, etc. The Governance Committee therefore provides assurance on the adequacy and effectiveness of risk management and integrated governance within the organisation.

Participation in Clinical Audit and the National Confidential Enquiries

Clinical audit is a way to find out if healthcare is being provided in line with standards and allows care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in hospitals or GP practices or indeed anywhere where healthcare is provided.

Participation in relevant national clinical audits (in a programme called the National Clinical Audit and Patient Outcomes Programme or NCAPOP) and national confidential enquiries (a form of national audit) is now required by the NHS England Standard Contract and Care Quality Commission guidance. The NCAPOP comprises more than 30 national audits related to some of the most commonly-occurring conditions. It involves the collection and analysis of data supplied by local clinicians to provide a national picture of care standards for any specific condition which is the subject of an audit. On a local level, NCAPOP audits provide local Trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help organisations identify necessary improvements for patients.

As well as the national clinical audits, NCAPOP also encompasses the national confidential enquiries. These have now been rebranded and are known as Clinical Outcome Review Programmes (for consistency and clarity these will continue to be called national confidential enquiries in this report). Participation in some of these has to be reported in Trust Quality Reports 2016/17. These enquiries help assess the quality of healthcare and stimulate improvement by enabling clinicians and managers to learn from adverse events and other relevant data.

During 2016/17, 45 national clinical audits and 6 national confidential enquiries covered relevant health services that City Hospitals Sunderland provides.

During that period City Hospitals Sunderland participated in 93% 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 2016/17 are as follows: (see table below).

The national clinical audits and national confidential enquiries that City Hospitals Sunderland participated in during 2016/17 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 2016/17, 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 and National Confidential Enquires 2016/17

National Clinical Audits 2016-2017	Eligible	Participation	Comment
Older People			
Falls and fragility fractures audit programme including:			
- National hip fracture database	✓	✓	371 cases (100%)
- Fracture liaison service database	✓	✓	1624 cases (100%)
- National inpatient falls audit	✓	✓	To commence May 2017
Sentinel stroke national audit programme (SSNAP)	✓	✓	528 (100%)
National audit of dementia	✓	✓	Fully compliant with study criteria. 80 clinical cases, Organisational proforma, carers' survey and staff survey completed
Women and Children's Health			
Neonatal intensive and special care (NNAP)	✓	✓	326 cases (100%)
Paediatric diabetes	✓	✓	192 children audited in 2016/17 based on 2015/16 patients
Paediatric intensive care (PICANeT)	N/A	N/A	
UK cystic fibrosis registry	N/A	N/A	Regional Centre Royal Victoria Infirmary
Paediatric pneumonia	✓	✓	77 cases (100%)
Acute Care			
Adult critical care (Case mix programme)	✓	✓	894 cases (100%)
National emergency laparotomy audit	✓	✓	168 cases (100%)
National joint registry	✓	✓	973 cases January to December 2016
Severe trauma (Trauma audit and research network)	✓	✓	335 cases (78.5%) January to December 2016
Nephrectomy audit (BAUS)	✓	✓	Data analysis is taking place by the national BAUS organisation of the 2016 submissions
Percutaneous nephrolithotomy (BAUS)	✓	✓	Data analysis is taking place by the national BAUS organisation of the 2016 submissions
Radical prostatectomy (BAUS)	✓	✓	Data analysis is taking place by the national BAUS organisation of the 2016 submissions
Severe sepsis and septic shock in emergency departments (CEM)	✓	✓	100 cases (100%)
Asthma (paediatric and adult) care in emergency departments (CEM)	✓	✓	100 cases (100%) 43 paediatric and 57 adult cases
Cancer			
Bowel cancer (NBOCAP)	✓	✓	336 cases (100%)
Head and neck cancer (DAHNO)	✓	✓	259 cases (100%)
Lung cancer (NLCA)	✓	✓	361 cases (100%)
Oesophago-gastric cancer (NAOGC)	✓	✓	23 cases (100%)
Prostate cancer	✓	✓	493 cases (100%)
Long term conditions			
Chronic kidney disease in primary care	✓	X	Incompatible information systems
Inflammatory bowel disease – IBD registry	✓	X	Not able to participate due to time constraints and staffing
Adult asthma	✓	✓	22 cases (76% of eligible cases) and Organisational proforma
Endocrine and thyroid	✓	✓	Data not available

National Clinical Audits 2016-2017	Eligible	Participation	Comment
Long term conditions			
Learning disability mortality review programme (LeDeR)	✓	✓	12 patents eligible for LeDeR Review (aged 4-74) Of these, 7 LeDeR notifications, were made, 4 initial reviews and 1 multi-agency review
National chronic obstructive pulmonary disease audit programme	✓	✓	Moved to continuous data collection Feb 2017
National diabetes audit programme including:			
- Adult diabetes audit	✓	✓	2520 patients submitted Aug 2016 for 2015/16 patients
- National diabetes inpatients audit	✓	✓	109 patients submitted September 2016
- National foot care audit	✓	✓	154 cases July 2014 to April 2016
- National pregnancy in diabetes audit	✓	✓	19 cases (100%)
National ophthalmology audit	✓	X	Issues of software compatibility and costs
Renal replacement therapy (Renal Registry)	✓	✓	635 cases (100%)
UK cystic fibrosis registry	N/A	N/A	Regional Centre Royal Victoria Infirmary.
Rheumatoid and early inflammatory arthritis	✓	✓	59 patients recruited at baseline for year 2 of audit
Stress urinary incontinence audit (BAUS)	✓	✓	34 cases (100%) data for 2016
Heart			
Acute coronary syndrome or acute myocardial infarction (MINAP)	✓	✓	354 cases (100%)
Adult cardiac surgery audit (adult)	N/A	N/A	
Cardiac rhythm management	✓	✓	218 (100%)
Congenital heart surgery (paediatric and adult cardiac surgery)	N/A	N/A	
Coronary angioplasty/national audit of PCI	✓	✓	723 (100%)
Heart failure	✓	✓	239 (68.5%)
National cardiac arrest audit	✓	✓	103 (100%) April to December 2016
National vascular registry	✓	✓	188 cases (100%)
Pulmonary hypertension	N/A	N/A	
Mental health			
Prescribing observatory for mental health	N/A	N/A	
Blood and transplant			
National comparative audit of blood transfusion programme including:			
- Audit of red cell transfusion in palliative care	N/A	N/A	
- Blood management in scheduled surgery	✓	✓	13 cases submitted (93%) of eligible cases
- Audit of transfusion associated overload	✓	✓	Audit commenced March 2017
Other			
Elective surgery (National patient reported outcome measures programme)	✓	✓	1,768 patients eligible for all elective procedures, pre-operative questionnaires completed 1155 (65.3%). April 2016 to Jan 2017
Specialist rehabilitation for patients with complex needs following major trauma	N/A	N/A	
National neurosurgery audit programme	N/A	N/A	

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)			
NCEPOD Mental Health	✓	✓	5 cases / 5 returned (100%)
NCEPOD Acute Pancreatitis	✓	✓	5 cases / 5 returned (100%)
NCEPOD Acute Non Invasive Ventilation	✓	✓	4 cases / 4 returned (100%)
NCEPOD Chronic Neurodisability	✓	✓	11 cases / 11 returned (100%)
NCEPOD Young People's Mental Health	✓	✓	6 cases / 6 returned (100%)
NCEPOD Cancer in Children, Teens and Young Adults	✓	✓	No eligible cases identified for City Hospitals

Source: Quality Accounts Resource 2010-2016 (Healthcare Quality Improvement Partnership)

National Confidential Enquires (Clinical Outcome Review Programmes)

As has been stated earlier these are collectively known as Clinical Outcome Review Programmes. We have amended our Trust guidance to reflect these changes. These enquiries or types of audit are designed to help assess the quality of healthcare by examining the way patients are treated in order to identify ways to improve the quality of care. City Hospitals continues to take part in all relevant enquiries. A detailed overview of our specific contribution to the medical and surgical programme: National Confidential Enquiry into Patient Outcome and Death is highlighted below.

The full list of current Clinical Outcome Review Programmes are noted below:

Enquiry title	Organisation	Acronym
Child death review database	In development - the National Perinatal Epidemiology Unit & University of Leicester	NPEU
Child health outcome review programme	The three year programme is delivered by National Confidential Enquiry into Patient Outcome and Death in collaboration with The University of Cardiff	NCEPOD
Learning disability mortality review programme	Run by NHS England, the Healthcare Quality Improvement Partnership (HQIP) and the University of Bristol	LeDeR
Maternal, newborn and infant clinical outcome review programme	National Perinatal Epidemiology Unit and the 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
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness	Centre for Suicide Prevention, University of Manchester	NCISH
National retrospective case record review programme	Royal College of Physicians	RCP

National Confidential Enquiry into Patient Outcome and Death

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is concerned with maintaining and improving standards of medical and surgical care. During 2016/17 City Hospitals was eligible to enter data into 4 NCEPOD studies. The tables below provide a summary of our participation:

Mental Health – reviews the quality of mental health and physical health care provided to patients with a significant mental disorder who are admitted to a general hospital

Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
5	2	5	2	5	1	2	2

Acute Pancreatitis - refers to inflammation of the pancreas, an organ that lies in the abdomen, which produces digestive juices and certain hormones, including insulin

Cases included	Cases excluded	Clinical Q returned*	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
5	0	5	0	5	0	1	1

Acute Non-Invasive Ventilation – explores avoidable and remediable factors in the process of care for patients who require support with breathing (ventilatory support through the patient's upper airways)							
Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
4	3	4	1	4	1	1	1

Chronic Neurodisability – reviews and identifies remediable factors in the quality of care provided to children and young people with chronic disabling conditions, focusing in particular on cerebral palsies							
Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
11	1	11	0	10	0	1	10

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

Young People's Mental Health- identify the remediable factors in the quality of care provided to young people treated for mental health disorders, with specific reference to: self-harm, eating disorders, depression and anxiety							
Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
6	0	6	0	6	0	NA	NA

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

Cancer in Children, Teens and Young People - to study the process of care of children, teens and young adults under the age of 25 years who died/ or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy							
Cases included ICU	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
0	0	0	0	0	0	NA	NA
Cases included SACT	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Organisational Q returned *
0	0	0	0	0	0	NA	NA

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

***Number of questionnaires/case notes returned including blank returns with a valid reason, questionnaires marked NA = not available, and case notes missing with a valid reason.

National clinical audits

The reports of 10 national clinical audits were reviewed by the provider in 2016/17 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided. These have been presented to Clinical Governance Steering Group although the reports of all national audits are reviewed through local clinical governance arrangements.

Audit title	Good outcomes / Actions taken
National Diabetes Foot Care Audit	• this audit was a continuous collection of data from 14th July 2014 up to 8th April 2016 and involved 154 patients; • basic demographics, Male, age 63yrs (younger than national average), either current or ex-smoker (42%) with a higher than national average level of social deprivation (52%), but better than national average level of diabetes control 52% on reaching NICE targets (43%); • 37.7% of patients with active ulcers were seen within 2 days compared to 13.4% nationally for the same time period, although we had a lower rate of self-referral 7% compared to national 29%. Active implementation of a self-referral process will address this; • ulcer healing at 12 weeks was 50% compared to national average 44%, and at 24 weeks healing was 57% compared to national average 58%; and • overall the diabetes foot MDT service at Sunderland is achieving above national average outcomes. By implementing and effectively recording a self-referral pathway we can aim to see patients presenting in a timely

	fashion with less severe ulcers, which should heal completely.
National Diabetes Audit – Care Processes (2016) – Sunderland Royal Hospital	• the audit looks at the structure, process and outcome of diabetes services, in firstly attaining the 8 key care processes in people with both type 1 (insulin dependent) and Type 2 diabetes, and secondly the attainment of three key essential treatment targets for blood pressure, cholesterol and glucose control. The data reported is from April 2015 – April 2016; • care process completion for people with Type 1 diabetes (61% vs 37%) and Type 2 diabetes (65% vs 53%), this was higher than expected as compared to national figures for all 8 key care processes – this data is consistent with previous years report; • attainment of all 3 treatment targets: treatment target achievement for people with Type 1 diabetes 11% vs 18% nationally. There has been improvement in blood pressure (52% increased to 65%) and cholesterol (29% increased to 33%) targets attained, blood glucose targets have only marginally improved compared to previous years (20% increased to 22%); • attainment of all 3 treatment targets: treatment target achievement for people with Type 2 diabetes 20% vs 40% nationally. There has been improvement in blood pressure (50% increased to 59%) and blood glucose targets have only marginally improved compared to previous years (35% increased to 37%); and • overall there has been improvement in attaining these targets as compared to previous data, a more structured approach in collaboration with patients as part of a Shared Decision Making process with great use of medication will be required, and incorporating the "Right Care" pathway could facilitate this.
National Inpatient Diabetes Audit	• the audit is a snapshot of diabetes in-patient care at City Hospitals Sunderland, which occurred on the 26th September 2016; • only 32% of patients were seen by a member of the Diabetes Team during their stay, compared to 34% nationally. This is less that previous years; • 90% of patients admitted with an active foot problem were seen within 24hrs by a member of Diabetes MDT, compared to national 56%. This high level has been maintained as part of the foot Protection Team service incorporating Podiatry, Vascular Surgery, DSN, Tissue viability and Diabetes Team; • harm resulting from in-patient stay: **Medication Errors** 25% compared to 37% nationally. **Prescription Errors** 9% compared to 21%. **Management Errors** 19% compared to 24%. **Insulin Errors** 19% compared to 22%. There has been year on year sustained improvement in these parameters above national average, but further IT solutions need to be established for safe insulin prescribing; • patient feedback report highlight lower levels of satisfaction with meal timing (56% satisfied, national 63%)and choice of meals (46% satisfied, nationally 54%), • it also highlights a knowledge gap and training needs for ward staff across the trust only 59% of patient felt that all or most staff knew enough about diabetes to meet their needs (nationally 65%); and • patients report high satisfaction levels with their overall care while in Sunderland Royal hospital 86% (nationally 83%).
National Care of the Dying Audit for Hospitals	• the aim is to improve the care for dying patients and those close to them in hospital settings. Comprises an organisational element and a case note review of selected patients; • the introduction of a new process for coordinating care for the dying will help with documentation; • some issues continue around communicating with those that are dying and their families. The Trust is reviewing how the views of bereaved relatives can be sensitively taken into account; • our new End of Life Facilitator will orientate staff training and awareness sessions following the audit findings; and • the Trust now undertakes detailed end of life reviews as part learning lessons from patient deaths.

UK Rehabilitation Outcomes Collaboration (UKROC)	• this is a national database of specialist rehabilitation activity and outcomes using validated measurement tools; • data is used to benchmark units against peers, to inform commissioning bodies of the cost and cost-effectiveness of rehabilitation, and to identify national trends; • our scores are consistent with peers for length of stay and referral-to-assessment time. We also have a shorter than average referral-to-admission time; and • our measures of disability (Functional Independence Measure & Functional Assessment Measure) efficiency at 0.8 points/day exceeds the national average of 0.5 which is good.
Sentinel Stroke National Audit Programme	• this is a continuous web-based data collection on the management of acute stroke and rehabilitation. Audit results are produced quarterly and available in the public domain; • stroke performance is assessed on 10 domains of care covering all aspects as the patient moves through the service; • some issues with data entry which has affected the quality of data submitted and the outcomes published; • some areas of good practice, i.e. access to quick brain scanning, availability of specialist assessments, appropriate stay on a stroke unit; • other areas require improvement, i.e. availability of therapy services across the full 7 day service, nurse staffing in the stroke unit; and • opportunity to improve audit performance with the local reconfiguration of stroke services.
Rheumatoid Arthritis and early Inflammatory Arthritis (2nd national report)	• includes patients aged 16 and over with inflammatory arthritis; • measures performance against 7 NICE Quality Standards – 'markers of excellence'. It also reports patient outcome measures, i.e. the RAID score (Rheumatoid Arthritis Impact of Disease Score); • there has been an improvement in performance in most of the standards compared with the first audit. In two standards (access advice via help-line & the availability of a yearly review) the Trust achieved 100% in each; • in only one standard was there a slight drop in performance, i.e. offering patients monthly treatment escalation; and • City Hospitals had the best improvement in RAID score in the region.
National hip fracture database (Annual report 2016)	• the database is a clinically led, web-based audit of hip fracture care and secondary prevention. The aim is to improve the delivery of care for patients having falls or sustaining hip fracture; • the Trust was in the top range of scores for: - patients being admitted to a ward <4 hours, - having a perioperative medical assessment (providing better conditions for patients before operation, during operation, and after their operation), - achieving the 'best practice tariff', i.e. elements of care that improve patient outcomes, - surgery on day of or day after admission, - return to original residence within 30 days • no measures of standards were in the bottom quartile of scores.

Local clinical audit

The reports of 125 local clinical audits were reviewed by the provider in 2016/17 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

Audit title	Good outcomes / Actions taken
Trauma & Orthopaedics - National Fracture Liaison Service (FLS)	• the FLS sees all patients aged 50 and over presenting to T&O with a fragility fracture (defined as a fracture sustained from a low impact fall from a standing height). The service has systems in place to identify and see patients on first presentation to T&O;

	• the FLS provides full bone health and falls screening and routinely submits data to the national database; and • the Trust is performing above the national average in the following areas: Dexa scan offered (a special type of X-ray that measures bone mineral density) = 64.2% (all eligible patients) compared to national fig. of 37.1%, patients undergoing falls assessment 70.8 % (national fig. 66.3%) and patients offered bone protection 69.7% (national fig. 52.1%).
Management of patients presenting with out of hospital cardiac arrest	• audit identified that clinical outcomes following cardiac arrest outside of hospitals are similar to published registry data; and • audit identified the parameters which can be used to predict good and bad patient outcomes. Using this data we will be producing a joint management algorithm (a set of instructions) for use in the Emergency Department, Cardiology and the Integrated Critical Care Unit.
Quality of discharge letters in vascular surgery	• an audit was done to evaluate the content of discharge letters, to make sure that appropriate information about the procedures was available to GPs, and on occasions, to hospital doctors if that patients was re-admitted; • following the initial audit, an induction booklet was designed and made available to all incoming junior doctors; and • a re-audit was undertaken in August 2016 involving a new intake of junior doctors rotating onto the unit, which showed 100% attainment of audit standards in discharge letters.
Management of supracondylar fractures in children (fractures above the elbow)	• this work audited records against several standards from the British Orthopaedic Association standards for trauma. It included only those cases that required surgical intervention. 65 children in total (aged 2–13); • generally good evidence of post-operative standards; and • Recommendation – development of standardised operation notes and follow-up protocol.
The quality of trauma theatre records: an audit using the Royal College of Surgeons 'Good Surgical Practice' as a Standard	• theatre records are required to document operative findings and set out post-operative plans. They are an important communication tool; • audit reviewed 93 records and compared compliance with a range of documentation standards; • repeat audit has shown many improvements in the quality of operation notes in trauma surgery; and • the introduction of an aide-memoire has been used to heighten awareness of the Royal College standards to relevant staff.
Ears, Nose & Throat (ENT) - Vestibular Testing Audit (tests the 'balance' part of the ear)	• the audit evaluated appropriateness of referral for testing, management of the outcomes following investigations and cost effectiveness; • findings show some time-consuming diagnostic tests were performed, which had minor contribution to the final diagnosis and treatment of the patient; • modification in the assessment methods of dizzy patients with emphasis on history and clinical presentation are required. As a result of the audit findings ENT will revisit joint clinics along with Audiology.
Ophthalmology - Lower Lid Surgery Audit	• The aim of the audit was to assess patient reported outcome measures after lower lid surgery. Results show the following: • For Entropion (eyelid folds inward) patients 100% had an improved symptom score (14 patient in total); • For lower lid laxity (sagging of eyelid) patients 13/15 (87%) had an improved score, 1/15 (7%) had unchanged score and 1/15 (7%) had a worse score; • Patients' comments were very positive for entropion patients: 'very pleased', 'best thing I had done'; • Mixed comments from lid laxity patients: 100% delighted with result, 'better than it was' and 'symptoms initially improved but returned'; and • The audit provides a new type of outcome data for lower lid surgery.

Research and Innovation

Clinical Research is core NHS business (NHS Constitution, 2009). 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 Government agenda. The NHS England "Research and Development Strategy 2013-2018", published in 2013 identified priorities for the promotion of research. "Innovation Health and Wealth" (2011) described the gap between the invention of new ideas and identification of best practice and their adoption and spread. Great innovations are often implemented quickly in one or two places but in the NHS, as in other health care systems, diffusion is slow, often taking many years.

The Research and Innovation Department are encouraging, enabling and extending research and innovation activity throughout the Trust, as evidence confirms that patients who participate in research trials have better clinical outcomes. We are working closely with both the National Institute for Health Research, Clinical Research Network Northeast & North Cumbria (NIHR CRN NENC) and the NENC Academic Health Sciences Network (AHSN) to ensure both research and innovation are supported and expanded within City Hospitals. We will continue to offer more opportunities for patients to be part of clinical research (supported by the NIHR CRN NENC) and will ensure we extend our links with local and nationally-based Small & Medium-sized Enterprises (SMEs) as part of the 'Technology Transfer' initiative (supported by the AHSN NENC).

Research delivery

It has been a very successful year for the Research and Innovation Department, delivering the National Institute for Health Research (NIHR) 'Portfolio' of research trials (i.e. clinical research trials *with direct benefit to NHS patients*). This is our main workload: the majority of these trials are based in other centres in the UK (or indeed abroad) with an appointed Principal Investigator ('PI'). This is the clinician at City Hospitals with overall responsibility for running the trial locally. Although historically, these have usually been consultants, we are keen to encourage research development in non-medical allied health professionals (NMAHPs). This year we have appointed members of our generic research nurse team as PIs to relevant trials.

We are also expanding the number of Chief Investigators ('CI') in the Trust; where City Hospitals is the trial centre leading our own research studies. We endeavour to ensure that wherever possible, these are adopted as NIHR NHS 'portfolio' trials. Mr David Steel (Ophthalmology), Mr Stuart McCracken (Urology) and Dr Ruppa Geethanath (Neonatology) are all Chief Investigators for commercially sponsored studies. Dr Nick Jenkins (Cardiology) will be CI in a joint study with the University of Sunderland (UoS) investigating coronary plaque disease. We have non-medical CIs and in particular Dr Jo Patterson in Speech & Language Therapy, who also holds a prestigious NIHR Academic Lecturer position. The Research and Innovation Department works closely with the UoS and other external bodies to develop our own joint research projects and to secure external funding. We continue to support student based research and non-portfolio trial work. Dr Karen Horridge (Paediatric Consultant) is a recognised lead in the UK and beyond in her specialty field of childhood disability. She has recently published guidelines which will guide good practice at both national and European levels, just one example of the far-reaching beneficial effects of work undertaken here in our Trust.

The number of patients receiving relevant health services provided or sub-contracted by City Hospitals in 2016/17 who were recruited during that period to participate in research approved by a Research Ethics Committee was 2098. Target recruitment set for City Hospitals by the NIHR CRN NENC for 2016/17 was 1648 and therefore we have exceeded the target by 450 (27.3%). This is the second year in a row that we have increased our total accrual, at a time when overall local network and national recruitment has fallen.

We have ensured that our annual NIHR CRN NENC budget (£1,158,079) was apportioned appropriately and delivered within variance. Our successful involvement in NHS commercially-sponsored research trials has brought in a total of £239,650 to the Trust in 2016/17. This has been distributed to those clinical directorates involved in the research ensuring that their costs are covered, but importantly this also means that the Research and Innovation Department has additional funds which will be used to support researchers at the Trust in implementing our Research and Innovation Strategy.

City Hospitals Sunderland is a member of the NIHR CRN NENC which delivers research under six clinical research delivery collective groups, i.e. Cancer, Circulatory and Endocrine, Medical Specialties, Children, Haematology, Reproductive Health and Childbirth, Genetics (CHaRGe) etc. Mr Kim Hinshaw is Clinical Research Lead for CHaRGe and is a member of the NIHR CRN NENC Executive Committee. A number of City Hospitals consultants are also appointed

to Specialty Group Lead (or Deputy Lead) roles for some of the 30 clinical specialties. Dr Deepali Varma is Specialty Group Lead for Ophthalmology, Dr Peter Carey is Specialty Group Lead for Diabetes, Dr David Coady is Specialty Group Deputy Lead for Musculoskeletal Diseases and Ms Yitka Graham is Specialty Group Lead for Health Services and Delivery Research. Neil Jennings has the role of Surgery (Endocrine and Upper Gastrointestinal) Sub Specialty Lead. Several Consultants across the Trust have shared the 13.4 Research PA sessions awarded and funded by the CRN NENC.

Dr Rachel Davison (Consultant Nephrologist) was awarded a competitive 'Greenshoot' research session to support commercial research and is now PI on a commercial study that is recruiting well. Julie Sheriff (Research Nurse in Critical Care) was also awarded a 'Greenshoot' research session to enhance clinical research activity in the ICCU here at City Hospitals working closely with Dr Alistair Roy who is PI in several clinical trials based in the unit.

We have a balanced research portfolio across many specialties and work closely and collaboratively with other Trusts within the network. The "Gastroenterology collaboration" has worked very well, increasing our involvement in trials in that clinical area. We are promoting collaborative working for cancer studies, with successful appointment of a Band 6 research nurse working across City Hospitals, South Tyneside Hospital and Queen Elizabeth Hospital, Gateshead. The Research Department continues to grow; we now have seven generic research nurses and two data managers to support research delivery across the Trust.

New appointments

We are very pleased to have recently appointed Dr Julie Cox (Consultant radiologist) to the role of Deputy Director of Research and Mr Steven Hogg as our first Patient Research Ambassador. Steven will be involved in initiatives to raise awareness of research participation. Our aim is to appoint further Patient Research Ambassadors, involving them more and more in delivery of our research strategy. Pauline Oates, Senior Research Nurse at City Hospitals is working closely with the Deputy Director of Research on several patient and public research initiatives at the Trust. We are planning several patient and public-orientated seminars to increase research awareness and these are being run collaboratively with our research colleagues at South Tyneside Hospital. Part of our five year Research and Innovation Strategy is to encompass working together as a single research unit, in line with the overall linkage developing across the South of Tyne.

We have developed a functional five year Research and Innovation Strategy (2016-21) which was presented to, and approved by the Trust Board in 2016.

The Innovation Department continues to work closely with the AHSN NENC and NHS Innovations North to facilitate and manage new innovative ideas generated within the Trust. We were very pleased with the recent appointments of two Deputy Directors for Innovation;

- Dr Deepali Varma (Consultant Ophthalmologist) leading developments in 'Point of Care' and clinical pathways; and
- Dr Imran Ahmed (Consultant Neonatologist) leading developments in 'Devices' and digital pathways.

Our new Deputy Directors encourage the submission of innovative ideas throughout the Trust and use their expertise to link with local SMEs and Universities to boost innovation development and output within City Hospitals. They work closely with our four 'Innovation Scouts' who continue to support ideas submitted from within their staff areas: Dr Dave Bramley (medical), Ruth Rayner (NMAHPs), Helen Nesbitt (nursing & midwifery) and Claire Dodds (support services). Finally, we were also pleased to appoint Dr Niall Mullen (Consultant in paediatric A&E) as City Hospitals Clinical Lead for Simulation. Niall will work closely with the Simulation team at the University of Sunderland to enhance simulation training across the Trust, with access to the new 'Living Labs' facilities at the University. The Labs include a state of the art, high fidelity simulation suite, as well as simulated wards etc. He will also work closely with the simulation group at Health Education England North East, looking at postgraduate training opportunities for medical, nursing, midwifery and non-medical allied health professionals.

Innovation recognition

The 'Bright Ideas' Awards is an annual ceremony to recognise innovative ideas from NHS Trusts throughout the region. This year saw two concepts developed in the Trust shortlisted for the annual awards:

1) Dr Prashant Kumar (Consultant Paediatrician) was shortlisted in the Innovation device/technology category for developing an 'Improved Spacer' for small children; and
2) Gary Musgrove (Urology Nurse Practitioner) and his team won the Service Improvement Award for developing, implementing and evaluating a 'Urology Rapid Access Unit'.

The City Hospitals/QHS ('Quality Hospital Solutions') ward beverage trolley was developed with the help of catering staff here at the Trust. Having won several innovation awards, it is now being marketed successfully across the UK, with an impressive increase in sales to other Trusts and non-medical companies this year. This generates funds which support delivery of our NHS work here at City Hospitals.

As an interactive department keen to develop a strong innovation culture, we continue to host multi-disciplinary seminars with invited external speakers. The seminars aim to enhance knowledge on pipeline treatments/devices, digital technology, new ways of clinical delivery and point of care and to also raise awareness on regional infrastructure in research and innovation. Our seminars are delivered by academic staff from local universities, industry experts from SMEs and research delivery leads from the CRN. This year the Department supported a SME ('Tookie') to help develop their innovative 'Tookie® vest' which helps patients to manage indwelling lines which allow long-term access to their veins etc. Dr Saeed Ahmed (Consultant Renal Physician) led the initiative, setting up patient focus groups to help develop a version of the 'Tookie Vest' which will fulfil the needs of renal patients undergoing regular haemodialysis.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) framework

The Commissioning for Quality and Innovation (CQUIN) 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 2016/17 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 2016/17 and for the following 12 month period are available electronically at www.chsft.nhs.uk.

For 2016/17, approximately £6.25m of income (£6.32m in 2015/16) 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 £5.86m (93.8%) (£5.84m in 2015/16) for the associated payment in 2016/17 relating to delivery of these schemes.

The full CQUIN scheme 2016/17 and where we have achieved our targets are highlighted below:

No	Topic	Indicator	Priority	Achievement*
1	Introduction of health and wellbeing initiatives	Improve staff access to musculoskeletal services and introduce mental health initiatives	National	
		Provision of healthy food options for all NHS staff, visitors and patients		
		Improve the uptake of flu vaccination among Trust staff		
2a	Sepsis Screening and management	Sepsis in Emergency Department (includes, screening, rapid antibiotic administration and review)	National	
2b		Sepsis in acute inpatient settings (Department (includes, screening, rapid antibiotic administration and review)		
3a	Reduction in antibiotic consumption	Reduction in antibiotic consumption per 1,000 admissions	National	
3b		Senior review within 72 hours of antibiotic prescriptions		
4a	Digital Roadmap	Optimising the e-discharge process	Local	
4b		Reducing Paper Information Flows		

4c		Active participation in the Local Digital Roadmap		
4d		Interoperability & Application Programming Interface (API) Capability		
4e		Access to the GP record		
4f		Deployment of solutions supporting Sunderland Vanguard		

5a	Physical health	Frailty - Promote a system of timely identification and proactive management of frailty	Local	
5b		Liver Cirrhosis – improve care and management within 24 hours (introduction of 'care bundle')		

6	Ambulance pre-booking	To increase the number of pre-planned discharge ambulance bookings to help facilitate patient discharge	Local	

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

Key

Full achievement

Partial achievement or further work on-going

Not achieved

Information relating to registration with the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally obligated to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the regulatory requirements of the CQC (Registration) Regulations 2009. From April 2015 all providers had to meet the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

City Hospitals Sunderland 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 during 2016/17.

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

City Hospitals Sunderland was visited by the CQC between 16 -19th September 2014 as part of their planned inspection programme. The CQC visit included services at Sunderland Royal, the Eye Infirmary and an assessment was made against the key questions; are services safe, effective, caring, responsive and well-led?

The inspection report was published in January 2015 and ratings received were:

- **City Hospitals Sunderland (Overall Provider)** **Good**
- **Sunderland Royal** **Requires Improvement**
- **Sunderland Eye Infirmary** **Good**

A breakdown of the ratings awarded for each of the five key questions used by the CQC in their inspection of services is highlighted below:

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

Following publication of the report, an action plan was agreed at the Quality Summit in January 2015, which included 'must do' areas for improvement, with the CQC also identifying a number of 'should do's'. The majority of these actions have been completed although both nurse staffing issues and performance within the Emergency Department reflect long standing national issues and therefore local resolution has been particularly challenging. Given the nature of these issues and in the knowledge that progress and achievements has been made in all the other areas it was agreed by the CQC that we could 'close' the action plan. However, these areas would continue to be monitored through existing Trust governance systems.

Church View Medical Centre (owned and run by the Trust) was also inspected at the same time as City Hospitals. The findings of this inspection were reported separately, but before ratings were introduced for primary care locations. A further inspection by the CQC in September 2015 gave the GP practice an overall rating of 'Good' with all the inspection elements also rated as 'Good' as shown below:

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

The practice has addressed all of the issues identified during the previous inspection (September 2014) with the exception that the practice could not demonstrate their approach to clinical audit and how they used this information to improve clinical practice. In October 2016 the CQC undertook a focused inspection where they asked the Trust to send them information to evidence that they had addressed the outstanding areas. The findings from the subsequent CQC report were as follows:

- The practice had taken action in relation to the requirements we issued at the last inspection. The practice had increased focus on clinical audit. There was a clinical audit plan in place and there was evidence this was discussed regularly through clinical and team meetings. The Trust provided us with several examples of completed clinical audit cycles; and
- The practice had also addressed those areas we told them they should consider improving. They had carried out a formal legionella risk assessment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). They had also updated their complaints leaflet to detail the arrangements for external resolution.

Care Quality Commission Mortality Alert (Intestinal Obstruction without hernia)

In October 2016 City Hospitals received a mortality outlier alert from the Care Quality Commission. Their analysis of mortality data showed a higher than average rate for the intestinal obstruction (without hernia) primary diagnosis group compared with peers. The alert asked the Trust to provide evidence of any analysis it had undertaken to review individual cases. It also asked for information to be provided about any improvements the service had made or planned to take. The Trust carried out an investigation of the identified cases and used the outcomes from the mortality case note reviews undertaken by the Mortality Review Group in its response to the CQC.

The Trust found no evidence of any serious issues relating to the quality of surgical intervention and in all cases the deaths were viewed as not being preventable given the patient's condition and presence of co-morbidities. Some actions were required to help improve the documentation of preoperative care for patients requiring emergency surgery. A revised care pathway for emergency surgical patients was introduced in 2016. In addition, there were some improvements required for recording of death certificate details in the patient records and for completing electronic discharge summaries. The Trust submitted its detailed report to the CQC and shared the findings with Commissioners. A subsequent letter from the CQC in December 2016 confirmed that they were happy with the review and response we had provided. They suggested that the monitoring of actions would be picked up by the local inspection team.

NHS Number and General Medical Practice Validity

City Hospitals Sunderland submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are then included in the latest published data and SUS dashboards. 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	100%	Percentage for outpatient care	100%
Percentage for accident and emergency care	99.6%	Percentage for accident and emergency care	99.9%

Actions taken to improve documenting the NHS number and General Medical Practice codes were:

- Increased frequency of the NHS Number batch trace process to daily from fortnightly.
- All staff who register new patients now have access to the National Spine and trained how to search for the NHS Number to always enter a complete record. This is monitored closely by Data Assurance.
- A daily report is generated to determine NHS number for patients attending ED. This is checked against the spine and entered retrospectively by the admin staff.
- Data Quality regularly run missing Master Patient Index reports and manually searches and fixes any records with blank NHS Number.
- Data Quality worked with Outpatient and Reception teams to script the booking in process. Patients are always asked to confirm their General Medical Practice and specified GP and the teams update the records appropriately at the point of patient contact.
- Prior to SUS transmission, Data Assurance 'bounce' all the General Medical Practice codes for all patient activity off the National Spine and add all exceptions to an error log which is then validated.

Quality of data - Information Governance Toolkit

The Information Governance (IG) 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. As part of the annual year-end self-assessment exercise, City Hospitals and Church View Medical Centre completed a review of all evidence against the Information Governance (IG) requirements within the IG Toolkit. Each requirement is scored from level '0' (i.e. worst) to level '3' (best). The final submission of the Toolkit was made by the 31 March 2017.

City Hospitals Sunderland's Information Governance Assessment Report overall score for 2016/17 was 87% (a slight increase to the compliance score from last year) and was graded Green (satisfactory). Church View Medical Centre's submission for 2016/17 was 89% (maintaining last year's compliance score) and is also graded Green (satisfactory).

The breakdown of the level scores is highlighted below:

City Hospitals Sunderland NHS Foundation Trust	Church View Medical Centre
This showed that of the 45 requirements, 45 were assessed as being at Level 2 or Level 3. In detail: • 17 show evidence that complete to Level 2; • 28 show evidence to Level 3. **The total percentage compliance for all initiatives is 87% = Satisfactory (coloured green).**	This showed that of the 13 requirements, 13 were assessed as being at Level 2 or Level 3. In detail: • 4 show evidence that complete to Level 2; • 9 show evidence to Level 3. **The total percentage compliance for all initiatives is 89% = Satisfactory (coloured green)**

Quality of data - Clinical coding error rate

Ensuring that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment given, is important to the effective management of our clinical services and the recovery of income for the care we deliver. The Trust has a continuous programme of audit and training in place to ensure high standards of clinical coding are delivered. City Hospitals Sunderland was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. This was in recognition that the Trust had achieved the highest attainment level (Level 3) as part of the annual Information Governance Toolkit (*No. 14.515 - an audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months*).

Part 2.3 Reporting against core indicators

NHS Foundation Trusts are required to report performance against a number of core mandatory indicators using data made available by NHS Digital (the new name for the Health and Social Care Information Centre). For each indicator the value or score for at least the last two reporting periods are presented. In addition, a comparison is made against the national average and those Trusts with the highest and lowest scores, where the information is publicly available.

Domain 1: Preventing people from dying prematurely

(i) Summary hospital-level mortality indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time, divided by the expected number given the characteristics of patients treated. A score above 1 indicates that a Trust has a higher than average mortality rate, whilst a score below 1 indicates a below average mortality rate, which is associated with good standards of care and positive outcomes. Each SHMI score reported is accompanied by a banding decision, either Band 1 (mortality rate is 'higher than expected'), Band 2 (mortality rate is 'as expected') or Band 3 (mortality rate is 'lower than expected').

This indicator is divided into two parts:

- (a) SHMI values and banding for the reporting period; and
- (b) percentage (%) of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period.

(a) SHMI values and banding

Indicator	Oct 14 – Sept 15	Jan 15 – Dec 15	April 15 – March 16	July 15 – June 16	Oct 15 – Sept16
Month of release	March 2016	June 16	Sept 16	Dec 16	Mar 17
City Hospital's SHMI	0.99	0.98	0.98	0.97	1.00
SHMI banding	Band 2	Band 2	Band 2	Band 2	Band 2
National average	1.00	1.00	1.00	1.00	1.00
Highest SHMI value – national (*high is worse*)	1.18	1.17	1.18	1.17	1.16
Lowest SHMI value – national (*low is better*)	0.65	0.67	0.68	0.69	0.69

Data Source – NHS Digital http://content.digital.nhs.uk/qualityaccounts

(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 however makes no adjustments for palliative care coding (unlike some other measures of mortality). This is because there is considerable variation between Trusts in the coding of palliative care. Therefore all patients who die are included in the SHMI measure, not just those expected to die.

Indicator	% of provider spells with palliative care coding (at diagnosis level)					% of deaths with palliative care coding				
	Oct 14 – Sept 15	Jan 15 – Dec 15	April 15 –Mar 16	July 15 – June 16	Oct 15 – Sept16	Oct 14 – Sept 15	Jan 15 – Dec 15	April 15 –Mar 16	July 15 – June 16	Oct 15 – Sept16
Trust	1.7	1.6	1.5	1.4	1.3	25.1	22.0	20.3	18.8	17.3
National average	1.5	1.4	1.5	1.4	1.5	26.6	27.9	28.4	29.1	29.6
Highest national	3.6	3.3	3.3	3.6	3.7	53.5	54.7	54.6	54.8	56.3
Lowest national	0	0	0	0	0	0.2	0.2	0.6	0.6	0.4

Data Source – NHS Digital http://content.digital.nhs.uk/qualityaccounts

City Hospitals Sunderland considers that this data is as described for the following reasons: The data is nationally mandated and internal data validation processes are in place prior to release. The Trust has approximately as many deaths as would be expected, given the range of services it delivers and the type of patients who are admitted to the hospital. The categorisation of the SHMI into Band 2 means that mortality is within the expected range.

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

- the ongoing strategic work of the Trust Mortality Review Group which monitors, reviews and challenges Trust mortality performance. The focus of its work and reporting format to the Board has been influenced by NHS England's Mortality Governance Guide which amongst others suggests that hospitals should receive information about overall crude mortality and numbers of deaths in high risk diagnostic groups, i.e. stroke, pneumonia, sepsis, fractured neck of femur etc;
- strengthening the governance of the Trust Mortality Review Panel process which has moved into its third year;
- improving aspects of clinical coding where data suggests our performance is below peer performance, i.e. recording of co-morbidities and the application of palliative care coding rules;
- continuing our participation in the Regional Mortality Group and associated streams of work;
- the Trust contributes data to the Regional Serious Infection Project (Sepsis and Community Acquired Pneumonia). Both these conditions have a major impact on patient mortality;
- continuing to work on quality improvements that might reasonably be expected to impact on mortality indicators. These include improving the identification and management of deteriorating patients, the screening and rapid treatment of patients with sepsis, ongoing work to refine emergency care, the prevention of falls and reduction in hospital acquired pressure ulcers and infections; and
- ensuring that information on all mortality measures is reported to and scrutinised by the Mortality Review Group, Governance Committee and Board of Directors when published.

Domain 2: Enhancing quality of life for people with long-term conditions

Indicators within this domain are not relevant to City Hospitals.

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

(i) Patient reported outcome measures (PROMS)

Patient Reported Outcome Measures (PROMs) aim to measure improvement in health following certain elective (planned) operations. This information is derived from questionnaires completed by patients before and after their operation. The difference between the two sets of responses are analysed to determine the amount of 'health gain' that the surgery has delivered from the viewpoint of the patient. The greater the perceived health gain, the greater the associated PROM score. The notion of health gain is determined from the EQ-5D Index score, this is derived from a profile of responses to five questions about health 'today', covering activity, anxiety/depression, discomfort, mobility and self-care. A weighting system is applied to the responses in order to calculate the 'index' score. All five questions have to be answered in order to do this. The higher the index score the better the patient feels about his or her health, with one (1) being the best possible score.

Information about our PROMS performance across the four elective procedures is highlighted below.

PROMS measure (EQ-5D index) Patients reporting improvement following:	2014/15 Adjusted average health gain	2015/16 Adjusted average health gain	2016/17 Adjusted average health gain	National England average 2016/17**
Hip replacement	0.394	0.429	- *	0.449
Knee replacement	0.331	0.334	- *	0.337
Varicose vein procedures	0.079	0.075	0.075	0.099
Groin hernia procedures	0.054	0.045	0.034	0.089

Data source – NHS Digital – Dataset 18: PROMS

* Less than 30 questionnaires, data is unreliable and therefore not published

**Reporting period covering April – Sept 2016 (provisional date published 9 Feb 2017)

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

- the Trust follows nationally determined PROMS methodology and the administration of the process is undertaken internally by the Clinical Governance Department working with Quality Health as our external analytics provider. PROMS data shows that in some of our elective procedures we are below the national averages although patients are still reporting health benefits from their surgery.

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

- reviewing routine PROMS outcomes data and sharing the information with clinical teams so that they can target improvements where necessary;
- reporting and reviewing PROMS performance at the Clinical Governance Steering Group and sharing the data with our Commissioners;
- investigating outlier PROMS performance to establish whether changes in the patient pathway are required; and
- exploring the potential to retrieve PROMS scores at individual consultant level as a mechanism to reflect and review surgeon's performance.

(ii) Emergency readmissions to hospital within 28 days of discharge

Emergency readmission indicators help the NHS monitor success in avoiding (or reducing to a minimum) readmission following discharge from hospital. Not all emergency readmissions are likely to be part of the originally planned treatment and some may be avoidable. To prevent avoidable readmissions it may help to compare figures with, and learn lessons from, organisations with low readmission rates.

This indicator looks at the percentage of patients aged (i) 0 to 15 and (ii) 16 and over readmitted to hospital within 28 days of being discharged.

% of patients readmitted to hospital within 28 days of being discharged from hospital (Large acute or multi service)	City Hospitals	National average	Highest national	Lowest national
2016/17*				
0-15 years	7.7%	9.3%	15.69%	0.45%
16 and over	6.9%	7.6%	10.44%	4.01%
2015/16				
0-15 years	7.1%	9.2%	18.7%	0.3%
16 and over	5.8%	6.6%	9.6%	3.2%
2014/15				
0-15 years	6.2%	8.5%	14.8%	0.6%
16 and over	5.3%	6.4%	9.3%	2.9%

Source – This indicator on the NHS Digital Indicator Portal was last updated in December 2013 and the next update is yet to be confirmed. Therefore, in the absence of national data information has been provided from our CHKS clinical benchmarking system.

*CHKS data only available April 16 – Dec 16

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

- the data is reported locally on the Trust's electronic performance monitoring system. Reducing readmissions remains a high priority for the Trust.

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

- continuing to review readmission data to identify emerging trends, i.e. the rate rising in a particular specialty, for a particular procedure or for a particular consultant. Where a trend occurs, we will undertake an audit of practice to see if we could have done anything differently to prevent the readmission;
- using our CHKS clinical benchmarking system to drill down to patient level data so that individual cases can be reviewed in detail, if required; and
- discussing readmission activity data and plans to reduce unnecessary readmissions at quarterly performance reviews with relevant directorates.

Domain 4: Ensuring that people have a positive patient experience

(i) Responsiveness to patients' 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 (Care Quality Commission). A high responsiveness rate suggests that a Trust is meeting the needs of its patients and acting effectively on their feedback.

The results are shown in the table below; the higher the score out of 100 the better the patient experience.

Composite score	2012/13	2013/14	2014/15	2015/16	2016/17
City Hospitals Sunderland	68.9	64.4	68.8	68.1	Not available
National average	68.1	68.7	68.9	69.6	Not available
Highest national	84.4	84.2	86.1	86.2	Not available
Lowest national	57.4	54.4	59.1	58.9	Not available

Data source - National Adult Inpatient Survey 2015 (Care Quality Commission)

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

- the Trust has a strong culture of quality and improvement and a good track record of receiving positive patient feedback most of the time. Where we have not achieved certain standards in the eyes of our patients we will do what we can, as quickly as we can, to address these issues. Strategic oversight of results from the National Adult Inpatient Survey is undertaken by the Patient, Carer and Public Experience Committee.

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

- demonstrating through changes in practice and our delivery of services that we have listened and acted on the patient feedback we receive. The results of this national survey will be used alongside our programme of local patient experience surveys, including our new 'Patient Experience Survey' to identify areas for improvement; and

- sharing results of local patient feedback with internal groups, wards and departments to enable them to reflect and then act on the results.

(ii) 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 standard of care in 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 (Acute Trusts only)	2013	2014	2015	2016	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"*	59%	65%	70%	70%	70%	85%	49%

Source – NHS Staff Survey 2016 (Picker Institute)
* Percentage calculated by adding together the staff who agree and who strongly agree with this statement

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

- the data published by the Picker Institute is consistent with the staff survey results received by the Trust for the 2016 staff survey.

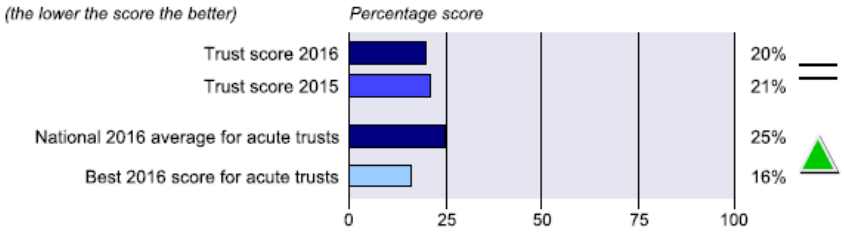
City Hospitals Sunderland intends to take the following actions to improve this percentage, and so the quality of its services, by:

- maximising staff participation in the Staff Friends & Family Test and the NHS Staff Survey and using the additional information provided to make changes to the work environment for all staff; and
- continuing to develop and monitor the Trust's action plan in response to the findings of the staff survey with updates for staff available on the Trust Intranet.

Last year, two additional indicators from the NHS Staff Survey were required to be included in Quality Reports. That request applies to the following two indicators:

Indicator (Acute Trusts only)	2014	2015	2016
KF21 – Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	88%	89%	87%
KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	18%	21%	20%

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

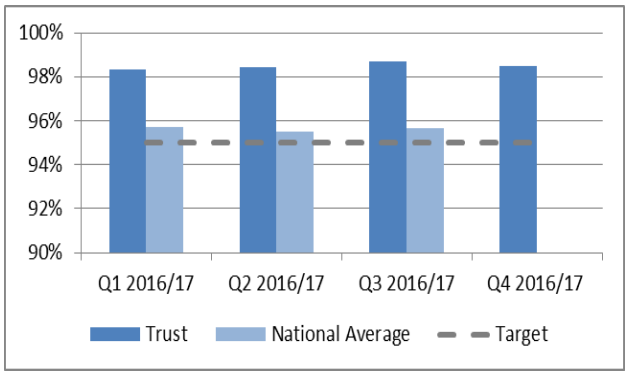


Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

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

National guidance has advised healthcare professionals, that all adults (older than 18 years of age) who are admitted to hospital should have a risk assessment completed to identify those patients most at risk of developing a blood clot. A high level of VTE risk assessments shows that a Trust is doing all it can to identify and address the factors that increase a patient's risk.

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



Reporting period	Trust	National Average	National Acute Range
Q1 2016/17	98.33%	95.73%	80.61% - 100%
Q2 2016/17	98.43%	95.51%	72.14% - 100%
Q3 2016/17	98.68%	95.64%	76.48% - 100%
Q4 2016/17	98.50%	Not available	Not available

2013/14 (95.35%)	2014/15 (97.61%)	2015/16 (98.28%)

Data source NHS England - https://www.england.nhs.uk/statistics/statistical-work-areas/vte/

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

- compliance with VTE assessments is reported monthly via the Performance Report. The above data is consistent with locally reported data and the Trust has consistently met and exceeded the national 95% target during the year.

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

- reviewing the Trust policy on the prevention of venous thromboembolism and restating the guidance on which patients should be subject to risk assessment (for some patients a risk assessment may not be clinically appropriate) so that they receive prompt and effective preventative measures;
- undertaking an audit of practice to ensure that patients who are assessed as 'at risk' of developing venous thromboembolism are prescribed appropriate anti-coagulation therapy in a timely and safe way;
- updating and revising the patient information leaflet on preventing venous thromboembolism; and
- responding to the findings from local clinical reviews if it is indicated that cases of VTE could have been prevented.

(ii) Rate of *Clostridium difficile* infection

Clostridium difficile is a bacterium (bug) that can be found in the bowel. It is found in healthy people and those who are unwell. About 3% of the population carry *Clostridium difficile* in their bowel without causing harm. There are millions of normal bacteria that live in the bowel which help keep *Clostridium difficile* under control. *Clostridium difficile* can become harmful when found in large numbers. When there is an imbalance of the normal bacteria of the bowel, *Clostridium difficile* may become present in large numbers. When this happens it produces toxins (like a poison) that affects the lining of the bowel and gives rise to symptoms such as mild to severe diarrhoea.

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)*				
	2013/14	**2014/15**	**2015/16**	**2016/17**
City Hospitals	18.1	18.7	29.2	9.02**
National average	14.7	15.0	14.9	Not available
Highest national	37.1	62.2	66.0	Not available
Lowest national	0.00	0.00	0.00	Not available

Source – NHS Digital Indicator Portal

* Some of the data values have changed following final publication

** Figure is post appeal process and measures against our nationally prescribed *C. diff* objective.

City Hospitals Sunderland considers that this data 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 continuing with our initiatives to reduce *C.difficile* infection, monitoring of infection prevention practices, and continuing with our antimicrobial stewardship programme.

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

All Trusts have a responsibility to ensure that there are measures put in place to report and learn from incidents and near misses. The table below shows the comparative reporting rate, per 1,000 bed days, for acute (non-specialist) NHS organisations for the most recent data period (1st April – Sept 2016). This data is based on incidents submitted to the National Reporting and Learning System by the 30 November 2016.

CHS reporting	Rate*	National average	Highest national	Lowest national
1 April 2016 – 30 September 2016	62.51	40.8	71.8	21.2
1 October 2015 – 31 March 2016	63.54	39.6	75.9	14.8
1 April 2015 – 30 September 2015	74.52	39.30	74.67	18.07
1 October 2014 – 31 March 2015	72.79	37.15	82.21	3.57
1 April 2014 – 30 September 2014	41.33	35.9	75.0	0.2
1 October 2013 – 31 March 2014	43.30	33.3	74.9	5.8

Source – Organisation Patient Safety Incident Reports (acute – non specialist) via NHS Improvement (latest data published 22nd March 2017)

* Incidents reported per 1,000 bed days

Incidents reported by degree of		City Hospitals	National average	Highest national	Lowest national
1 April 2016 – 30 September 2016	Severe Harm	16 (0.2%)	0.3%	1.4%	0.0%
	Death	3 (0%)	0.1%	0.5%	0.0%
1 October 2015 – 31 March 2016	Severe Harm	5 (0.1%)	0.3%	1.7%	0.0%
	Death	1 (0%)	0.1%	1.1%	0.0%
1 April 2015 – 30 September 2015	Severe Harm	9 (0.1%)	0.4%	2.9%	0.0%
	Death	3 (0%)	0.1%	0.7%	0.0%

1 October 2014 – 31 March 2015	Severe Harm	4 (0%)	0.4%	5.2%	0.0%
	Death	0 (0%)	0.1%	1.1%	0.0%
1 April 2014 – 30 September 2014	Severe Harm	10 (0.25%)	0.4%	2.3%	0.0%
	Death	1 (0.0%)	0.1%	0.8%	0.0%
1 October 2013 – 31 March 2014	Severe Harm	14 (0.23%)	0.5%	2.97%	0.01%
	Death	3 (0.05%)	0.1%	0.31%	0.0%

Source – Organisation Patient Safety Incident Reports (acute – non specialist) via NHS Improvement (latest data published 22nd March 2017)

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

- the Trust actively promotes the reporting of patient safety incidents and has revised its internal processes for staff during 2016. These enhancements will improve even further incident reporting among Trust staff.

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 hospital staff.

PART 3: OTHER INFORMATION – REVIEW OF QUALITY 2016/17

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. Also some of these continue from last year given their scope, complexity and requirements for improvement.

In keeping with the format of the Quality Report, indicators will be presented under the headings of patient safety, clinical effectiveness and patient experience. Later in this section, performance will be summarised against key national priorities.

	Indicator	Objective	Rating
Patient Safety	Improve the completion, documentation and visibility of DNACPR orders	10% improvement by Quarter 4	Partially achieved
	Improve the reporting and investigation of hospital associated VTE events	Implementation of a revised process for RCA investigations	Fully achieved
	Reduce the number of patient falls that result in serious harm	To sustain position of being below the regional and national averages	Fully achieved
Clinical Effectiveness	Improve the process of fluid management and documentation	Increase % for each element of the assurance audit undertaken in Jan 2016	Partially achieved
	Improve the assessment and management of patients with sepsis	- 90% of patients are screened for sepsis; - 90% of patients are given intravenous antibiotics within 1 hour of arrival in the Emergency Departments or 90 minutes from the possibility of sepsis for inpatients with the most severe form of sepsis; - 95% of patients have their antibiotics aND reviewed within 72 hours of administration	Fully achieved Fully achieved Fully achieved
	Reduction in the number of avoidable cardiac arrests	Improvement of 5% for 2016/17	Partially achieved
Patient Experience	Reducing cancellations of outpatient consultations	10% reduction during 2016/17	Partially achieved
	Improve the timeliness of response to patient complaints	Reduce the backlog of complaints to <20%	Fully achieved
	Increase the % of patients who reported they had a positive experience (Q72 - Overall……..)	Improve score against 2015 performance (2015 = 8.1/10)	Data not yet published

3.1 Indicators for Improvement

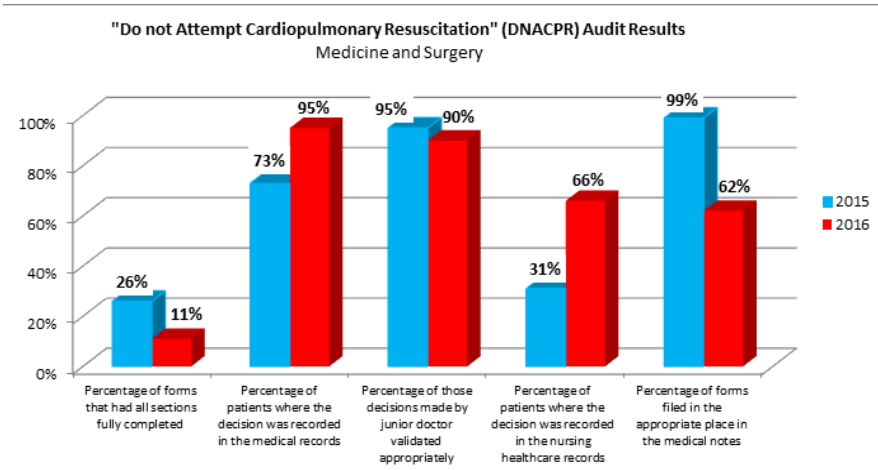
Indicators for improvement	Focusing on Patient Safety

1	Improve the completion, documentation and visibility of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders
2	Improve the reporting and investigation of hospital associated VTE events
3	Reduce the number of patient falls that result in serious harm

1 Improve the completion, documentation and visibility of DNACPR orders

Communicating DNACPR decisions can be particularly challenging for healthcare professionals. However, failure to explain clearly to patients or those close to them why decisions about cardiopulmonary resuscitation (CPR) are needed, and in particular the basis for a DNACPR decision, can lead to misunderstanding, potentially avoidable distress and dissatisfaction, and in some instances complaints or litigation. The chance of survival following CPR in adults is between 5-20% depending on the circumstances. Although CPR can be attempted on anyone, there comes a time for some people when it is not in their best interests to do this. It may then be appropriate to consider making a DNACPR decision to enable the person to die with dignity.

A DNACPR decision is a clinical one based on the patient's best interests, but it is important that the patient and relatives (if the patient is happy for them to be included) are involved at an early stage. Communication around DNACPR is very subjective and it is difficult to ensure that this communication has been effective and understood by patients and their family. In order to assess whether communication regarding DNACPR has taken place with patients and families, the Resuscitation Department undertake a twice yearly audit of documentation in medical and nursing notes to assess whether all sections of the DNACPR form have been completed. This does not measure the effectiveness of the communication, only that it has taken place.



The adjacent graph shows a comparison of the completeness of DNACPR documentation during 2015 and 2016. The picture is mixed with some evidence of improvement, i.e. a 22% increase in the times the decision is documented in the medical notes and a 35% increase in recording in the nursing notes. However, in some other areas documentation has failed to improve.

During the year the Resuscitation Trainers have delivered training to junior doctors at their induction about the process and documentation of DNACPR, including when to involve patients and families. They have adapted for use the national DNACPR patient information leaflet produced jointly by the Resuscitation Council, British Medical Association and the Royal College of Nursing. They have also developed a standardised DNACPR training package which includes communication with patients and families that all staff can access via electronic staff record.

We hope that in consolidating these training and educational initiatives we can show more sustained improvements in 2017/18. We will explore the possibility of introducing an electronic DNACPR form linked to our Meditech system (electronic record) to help with compliance. In addition, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is being devised by the UK Resuscitation Council with other national bodies, to improve the frequency and quality of recording DNACPR decisions.

2 Improve the reporting and investigation of hospital associated VTE events

Venous Thromboembolism (VTE) assessment is a national patient safety initiative to reduce avoidable deaths from blood clots that may develop as a result of admission to hospital. When patients are assessed and treated appropriately, it can significantly reduce rates of mortality associated with this condition. National guidance states that Trusts should undertake an investigation of all confirmed cases of thromboembolism acquired in hospital or occurring within 90 days after discharge following a hospital stay of at least 24 hours. The findings from any investigations should be reported internally to a relevant Trust Committee and any learning points should be shared with Commissioners.

During 2016, the Trust Venous Thromboembolism Group coordinated a review of the current investigatory process and strengthened governance arrangements in key areas, such as;

- Ensuring that the new process is much more clinically led, i.e. involving the Consultant who has clinical responsibility for the patient and making sure that the VTE Group has oversight of the whole process;
- The Chair of the VTE Group is now responsible for reviewing a cohort of patients on a monthly basis to ensure that they appropriately meet the review criteria, i.e. a new episode of VTE occurring during a hospital stay or a patient having been readmitted within 90 of discharge following an inpatient stay of at least 24 hours. This will allow identification of genuine cases for clinical review;
- The responsible consultant for each confirmed case now undertakes a case review using the national proforma and a judgement is made on whether the episode could have been prevented and what should have happened; and
- The outcomes of all cases, and any actions needed by the Trust, is presented at the quarterly VTE Group before a composite report is shared with Commissioners.

The revised process was introduced later than planned with the first summary report presented to the VTE Group in February 2017. The process is working well and the findings from these reviews will provide valuable information as to how we can further improve our assessment and management of this largely preventable condition.

3 Reduce the number of patients falls that result in serious injury

In-hospital falls are among the most common incidents reported in hospital and are a leading cause of death in people aged 65 or older. 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, since these may decrease the likelihood of a return to previous levels of independence for patients following a prolonged hospital stay.

Over the last 3 years the Trust has been consistently below the reported peer average for patients suffering harm from a fall in hospital. This position is supported by the results from the last national audit of inpatient falls (Royal College of Physicians), which shows that City Hospitals is the top performing Trust in the region. The audit measures practice against NICE guidance on falls assessment and prevention (NICE Clinical Guideline No.161) as well as other patient safety guidance on preventing falls in hospital.

The Trust has used data from the NHS Safety Thermometer to review the success of its approaches to falls prevention and management. The tables below show a consolidation of our position of being below (which is good) the regional and national averages for patients suffering harm from a fall in hospital.

Number of Patient Falls 2016/17													
	Apr 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	
Low Harm	0	0	2	0	2	1	1	0	3	2	2	0	13
Moderate Harm	0	0	0	0	0	0	0	0	2	0	0	0	2
Severe Harm	0	0	0	0	0	0	0	0	1	0	0	0	1
Death	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**0**	**2**	**1**	**1**	**0**	**6**	**2**	**2**	**0**	**16**
Total for 2015/16	4	1	2	2	0	2	0	0	5	1	2	3	22

Source – NHS Safety Thermometer Data

Metric		Apr 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Ave
Falls (Harm Rate)	Peer Min	0	0	0	0	0	0	0	0	0	0	0	0	0
	Peer Max	2.11	2.07	1.77	1.89	4.21	2.69	2.50	2.15	2.22	3.58	2.74	1.68	**2.47**
	Peer Ave	0.45	0.43	0.43	0.39	0.43	0.44	0.43	0.39	0.45	0.45	0.41	0.37	**0.42**
	Trust	**0**	**0**	**0.33**	**0**	**0.33**	**0.15**	**0.16**	**0**	**0.91**	**0.30**	**0.28**	**0**	**0.21**

The Hospital Falls Reduction Group has responsibility for leading the strategic work of the Trust and for ensuring that our initiatives succeed in preventing and managing patient falls. They also regularly review performance data and target their expertise and support to areas that require it. The reduction of patient falls is an ongoing priority for the Trust and we will continue to work to sustain our reputational position as being one of the best Trusts in region. We look forward to our participation in the next round of the RCP audit due to start in 2017/18.

Other Information - Sign Up to Safety Campaign

The national Sign Up to Safety Campaign aims to strengthen patient safety in the NHS and make it the safest healthcare system in the world. We wanted to translate that ambition to some of our local patient safety work and that is why we joined the campaign and pledged to reduce:

- the number and severity of hospital acquired pressure ulcers;
- the number of serious patient falls; and
- those medication errors that cause harm to patients.

We initially developed an overarching patient safety improvement plan but over time this has changed as we moved some of the topics to become our quality priorities. Therefore we have signed up to detailed improvement plans to support each of the quality priorities where appropriate e.g. Pressure Ulcer Improvement Plan, Fall Reduction Plan etc. Progress and achievements in reducing pressure ulcers and patient falls causing injury can be found in the section 2.1 - Review of Priorities for Improvement 2016/17. In addition, we were successful in bidding for national funding in 2015 to help the Trust mitigate risk and improve safety in three initiatives within Maternity and the Emergency Department. These projects included:

- introduction of a computerised system for the centralised monitoring of women whilst in labour;
- the introduction of high-tech support for the identification of high risk cases early in pregnancy; and
- collaboration between our Emergency Department and Radiology Service to improve reporting times for x-rays during evenings and weekends.

All three funding initiatives have now been implemented although the joint Emergency Department / Radiology work did suffer from some delay but is now under way.

Duty of Candour

When things go wrong it's important to our patients that we are open and honest regarding what has happened. We have a duty to do this – the duty of candour. The duty of candour is now a statutory requirement, complementing the existing professional duty for healthcare professionals. Our aim is that in all cases where duty of candour is applicable we will discharge our obligation to:

- notify the relevant person that the incident has occurred;
- apologise;
- provide reasonable support to the relevant person in relation to the incident;
- provide details of any investigations that will be required;
- provide results of any further enquiries into the incident; and
- write to the relevant person detailing all of the points above.

The Patient Safety and Risk Team collate details of patient incidents of a moderate/serious nature where duty of candour applies via the Trust incident reporting system. During 2016/17 the following incidents which require duty of candour have been reported:

	Q1	Q2	Q3	Q4
Incidents which require duty of candour 2016/17	60	42	10	6

Patients involved in incidents where harm has occurred receive an apology from staff and are provided with a full and clear explanation. The Trust Rapid Review Group will commission an investigation into each incident and following completion patients are invited to receive feedback via a face to face meeting and receive a copy of the investigation report.

During 2016/17 work has been ongoing to ensure the appropriate classification of the actual impact of reported incidents in accordance with both local and national guidelines, this means that publishing of data is delayed by 1 month to allow for thorough analysis and investigation. As the work has progressed during Q1 and Q2 there was a marked reduction in the number of confirmed Duty of Candour cases, this has now begun to plateau. By ensuring that incidents are appropriately classified this allows resources to be effectively targeted and to further progress this work during Quarter 1 of 2017/18 there will be staff awareness raising sessions and additional guidance provided to assist staff in effectively discharging their duty of candour responsibilities.

Never Events

Never events are patient safety incidents that are serious and largely preventable. They have the potential to cause serious patient harm or death. Any report of a never event is escalated via our serious incident process and subjected to root cause analysis investigation, so that learning is identified and shared appropriately. The Trust declared three never events during 2016/17, but none of the patients came to serious harm or death. A brief description of what happened in each case is provided below:

Description of Goal	12/13	13/14	14/15	15/16	16/17
Preventing occurrence of any 'Never Events'	1	1	1	3	3

Source – Strategic Executive Information System (STEIS)

Patient 1 - Wrong route administration of medication. A patient requested analgesia. A registered nurse measured out the prescribed liquid oramorph in a syringe, intended for oral administration, but was interrupted by an agitated visitor. The nurse asked a student nurse to give the patient the medication so that she could deal with the visitor at the nurses' station. The student nurse realised she had administered the oramorph via the wrong route: the patient had stretched out their arm and she gave it intravenously rather than orally. The incident caused minor harm to the patient. The incident was discussed at the Trust Rapid Review Group and a comprehensive investigation as to what happened was undertaken, relevant learning points are being implemented by the Trust.

Patient 2 - Retained foreign object post-procedure. A female patient in our maternity department had an instrumental delivery and subsequent birth of her baby. During the postnatal period the lady complained of a foul smelling discharge. The community midwife examining the woman observed what appeared to be a retained swab and referred her for immediate medical review. The woman was seen by medical staff at the Antenatal Day Unit and the swab was removed. This incident was graded as having caused minor harm and action I snow being taken by the Trust following investigation and reflection on the findings.

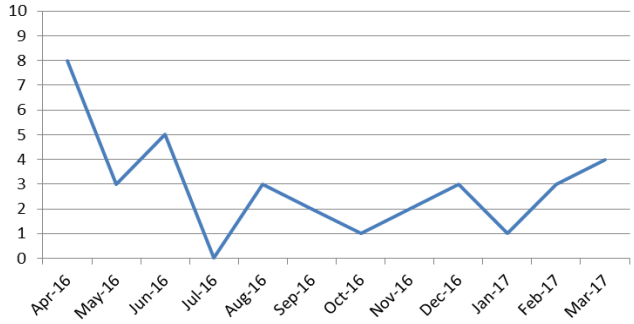
Patient 3 - Wrong-site surgery. A female patient required a surgical 'taping' procedure to help manage stress incontinence. The procedure involves making a small incision however this was wrongly located for the type of procedure. The error was immediately identified and corrected. The incident was graded as having caused minor harm and the Trust is currently carrying out a full investigation, the learning and any results actions from this will then be put into place.

Serious Incidents

Serious Incidents (SIs) in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The Trust is committed to identifying, reporting and investigating SIs, and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence.

SIs are reported via the Strategic Executive Information System (STEIS) and monitored through the North East Commissioning Support Unit (NECSU). Each incident is subject to a full root-cause analysis and the deadline for completing SI investigations is 60 working days from the date reported to STEIS. There are occasions when the Trust has not been able to meet this reporting standard and completed its investigations. The risk team are working closely with directorates to assist in completing all overdue SI investigations. Sunderland Clinical Commissioning Group has an established Serious Incident Panel in place to review all completed root-cause analysis reports, consider requests for 'downgrading' incidents and for closing investigations. The chart and table below show the number of SIs reported to STEIS (April 2016 – March 2017); 35 Serious Incidents have been declared by City Hospitals in 2016/17. The top five cause groups are also shown:

Number of Serious Incidents reported to STEIS (April 16–March 17)



Serious Incidents – top five cause groups (April 16-March 17)

Cause Group	Number
Tissue Viability	9
Slips/Trips/Falls	5
Surgical invasive procedures	3
Delay in attending to patient	2
Medicines administration	2

As can be seen elsewhere within the Quality Report, the top cause groups are identified within our Trust quality priorities and each has a plan for improvement with targets set to measure progress and achievement. So for example, we have a 3-year Trust-wide Pressure Ulcer Improvement Plan and the Hospital Falls Reduction Group is leading on a number of initiatives to reduce falls that cause injury to patients.

Indicators for improvement — Focusing on Clinical Effectiveness

1	**Improve the process of fluid management and documentation**
2	**Improve the assessment and management of patients with sepsis**
3	**Reduction in the number of avoidable (predictable) cardiac arrests**

1 Improve the process of fluid management and documentation

Accuracy in recording fluid intake and output is vital to the overall management of certain patient groups and facilitates the assessment and evaluation of the patient's condition. However, recordings on fluid balance charts are often being inadequately and inaccurately completed. This was one of the findings from the quality inspection undertaken in 2014 by the Care Quality Commission. Subsequent audits undertaken as part of the Trust's Assurance Programme over 2015 and 2016 have revealed similar findings that the standard of some of our fluid balance recordings must be improved.

Fluid Balance Chart Audit of Results			
	May 2015	Jan 2016	Sept 2016
Any special instructions written?	N/R	15.5%	11.2% ↓
Chart completed fully over 24 hours?	49.5%	78.4% ↑	78.3% ↔
Drinking water available next to patient?	73.9%	80.4% ↑	79.0% ↔
IV infusions prescribed and given during time period?	18.0%	(no % given)	(no % given)
Were these IV infusions recorded on fluid balance chart?	12.6%	78.3% ↑	67.6% ↓
Does output appear to be accurately recorded?	18.0%	43.3% ↑	28.7% ↓
Number where output not accurately	82.0%	56.7% ↓	71.3% ↑

The results of the latest audit undertaken in Sept 2016 show improvement in some areas but deterioration in others.

A review of practice revealed that the fluid balance charts were being utilised to merely monitor and record fluid input in patients where their output/balance was not necessarily critical to their clinical

recorded			
If output not accurately recorded, is frequency of passing urine recorded rather than the volume?	28.8%	59.7% ↑	89.2% ↑
Balance box completed?	10.8%	38.1% ↑	31.5% ↓
Fluid balance summary chart in place?	27.9%	34.0% ↑	44.1% ↑
Does fluid balance summary chart cross check with fluid balance chart?	20.7%	57.6% ↑	71.4% ↑

condition.

The Nutrition Steering Group has set up a "Task & Finish" group to improve practice in this area.

Following the latest set of audit results, the Task & Finish group has developed a Fluid Balance & Fluid Management Improvement Plan with an associated action plan. The focus of the plan is to ensure that robust patient assessment determines the patient's individual monitoring requirements, in terms of either fluid intake and output or merely fluid intake monitoring and recording. The group re-designed the existing Trust fluid balance chart, adding an explicit monitoring section onto the chart to clearly identify the patient's monitoring requirements and renaming it a "fluid monitoring chart". This chart was piloted in Quarter 4 2016/17 and evaluated extremely positively.

Plans for 2017/2018

- The Task & Finish group will ask the Clinical Governance Steering Group to approve the new fluid monitoring chart and lead on the implementation and roll out of new chart across the Trust;
- To define the required standards for fluid monitoring and recording within the Nutrition & Hydration policy and develop an associated Standard Operating Procedure (SOP);
- Assurance Team to re-audit fluid monitoring and recording charts in Q2 2017/18 (following roll out); and
- Nutrition Steering Group will continue to drive improvements in relation to nutrition and hydration across the Organisation.

Nutrition and hydration week (13th – 19th March 2017)

The Trust's Nutrition Steering Group (NSG) co-ordinated and led on a range of themed events over the week, under the strapline ***"Eating for Health".*** The purpose of the week was to highlight the importance of adequate nutrition and hydration within the healthcare sector.

The Trust's Nutritional Link Nurses played a key role by "championing" the week's activities and also promoting protected mealtimes for our patients.

The highlight of the week was undoubtedly the "Afternoon Tea Event" on Wednesday 15th March, which was funded using charitable funds supplemented by a contribution from G4S. A range of volunteers assisted our catering and domestic teams in preparing and serving the teas.

The event was extremely well received by patients, visitors and staff alike and seemed to strike a real chord with our care of the elderly patients in particular, with several patients asking for seconds and even getting themselves out of bed to get them!

Thank you to all involved, a great example of real teamwork in CHS!

2 Improve the assessment and management of patients with sepsis

Sepsis is one of the leading causes of death in hospital patients and severe sepsis has a significantly high mortality rate despite various campaigns and the availability of good evidence for treatment. The high death rate associated with sepsis is mainly due to poor identification and delayed intervention. Sepsis is now part of CQUIN and hospitals are

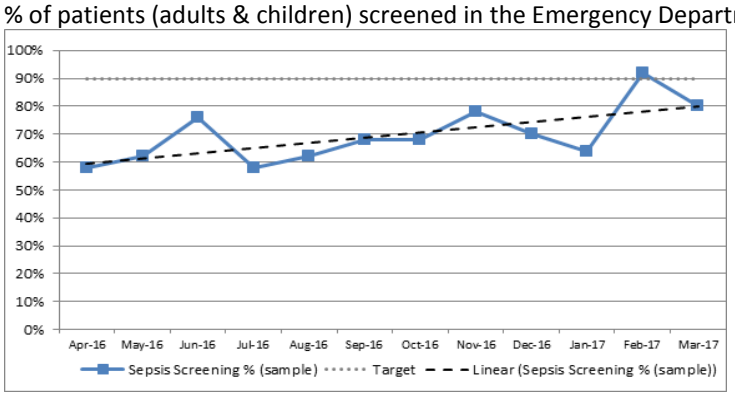
expected to set up systems for screening patients for sepsis for whom it may be appropriate. The aim is to identify quickly those patients with sepsis and who require rapid antibiotic treatment within 1 hour.

The Trust has a sepsis screening process now in place in adult and paediatric Emergency Departments, medical and surgical admissions units and across all in-patient wards. The targets set within the national quality scheme (CQUIN) for 2016/17 in Emergency Departments were:

- 90% of patients are screened for sepsis (where clinically appropriate);
- 90% of patients are given intravenous antibiotics within 1 hour of arrival in the Emergency Department; and
- 95% of patients who receive antibiotics have an antibiotic review within 72 house of first administration.

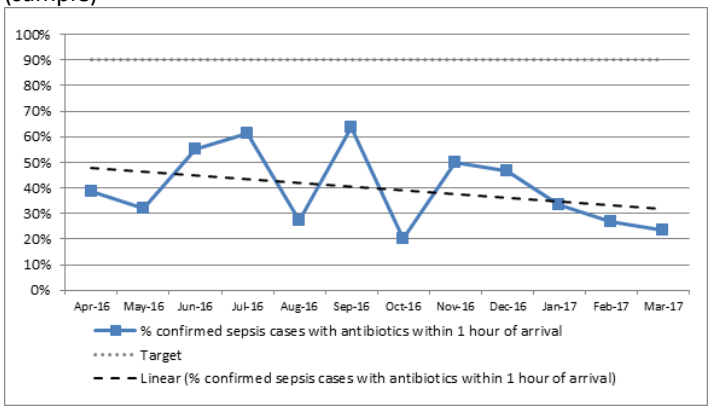
Emergency Departments

% of patients (adults & children) screened in the Emergency Department 2016/17 (sample)



CQUIN recognises partial achievement as performance above 50% throughout the year and 90% and above as full achievement. The chart shows incremental improvement and an upward trend line trajectory during the year (which is good). The 90% threshold was first achieved in Feb 2017.

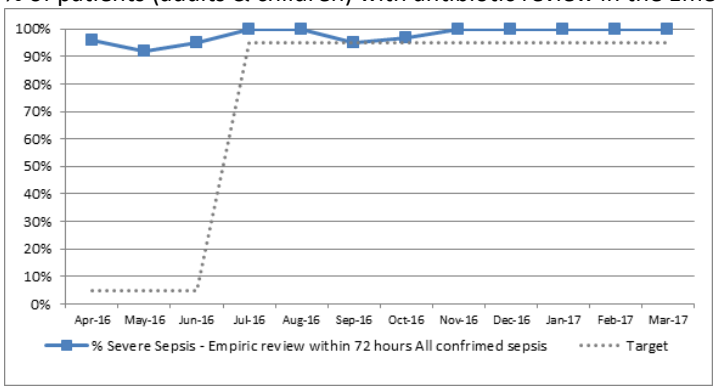
% of patients (adults & children) given antibiotics in the Emergency Department within 1 hour of arrival 2016/17 (sample)



CQUIN recognises partial achievement as above 50% throughout the year and full achievement would be 90%. We were only able to meet the partial achievement threshold on a limited number of occasions.

NHS England has now changed the criteria that will be applied to antibiotic administration and the Trust will therefore see an improvement in compliance in 2017/18.

% of patients (adults & children) with antibiotic review in the Emergency Department within 72 hours (sample)



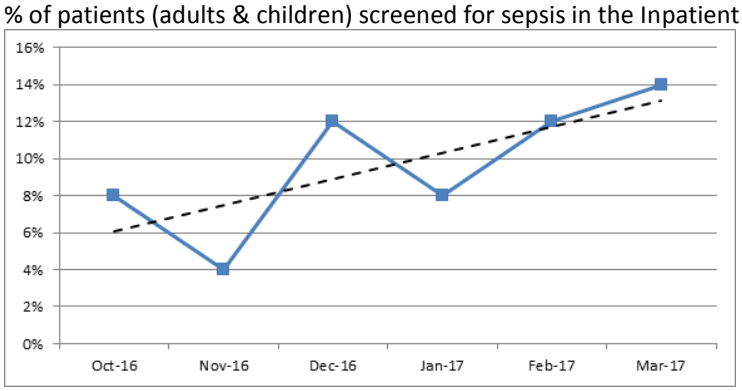
The initial target set with Commissioners was 5% for the first quarter 2016/17. This was revised and substantially increased to 95% following the first quarter data submission. The chart shows that the Trust consistently achieved this high threshold of performance throughout the full CQUIN year. Timely antibiotic review is important as it ensures that patients are on the right drugs, at the right dosage given at the most appropriate intervals.

Inpatient wards

For 2016/17, the CQUIN guidance confirmed that the screening process and instruction for rapid administration of antibiotics for patients with the most severe form of sepsis should apply to all inpatient areas. This presented an even

greater challenge to the Sepsis Group who were leading the Trust-wide implementation and to those wards asked to incorporate a new electronic screening tool into their admission process. The guidance would also apply to patients whose clinical condition deteriorated at any time during their hospital stay.

% of patients (adults & children) screened for sepsis in the Inpatient environment (sample)



Between April–September 2016, the Trust rolled out sepsis screening to all inpatient wards on a phased basis. Between October – December 2016 we were able to collect and verify data to provide a baseline figure for setting a target with Commissioners for quarter 4. This was agreed outside the national targets. We achieved the target set.

From a low starting point we can see an encouraging upward trajectory. However, inpatient wards present many different challenges regarding implementation and embedding practices.

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Antibiotics within 90 minutes	-	-	100%	100%	88.9%	75%
Antibiotic review within 72 hours	-	-	100%	100%	100%	100%

What have we done this year?

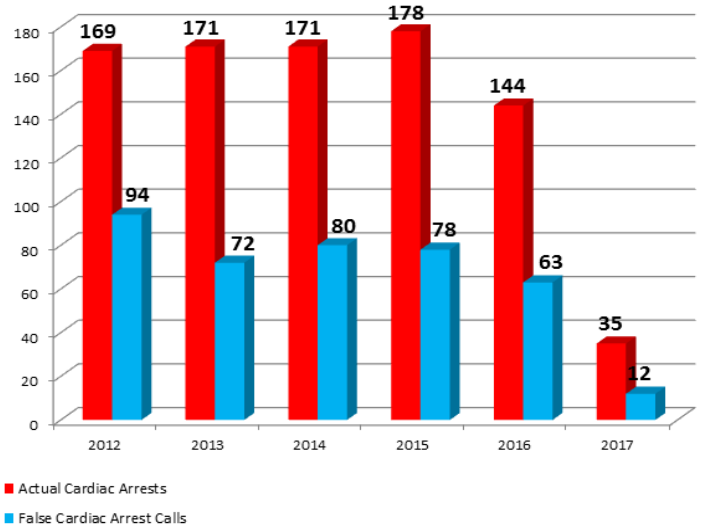
- City Hospitals has participated in a regional Sepsis Group chaired by Health Education England to look at standardising the tools used to recognise sepsis and to raise awareness and educate staff about sepsis;
- our sepsis process has taken account of recent NICE guidance on sepsis and moved to the Sepsis 3 international definition of sepsis;
- we have held a series of educational 'lessons learnt' seminars open to all staff around the recognition, treatment and management of sepsis (see adjacent poster);
- a number of drop-in-sessions were arranged by the Critical Care Outreach Team to answer any queries staff have about sepsis;
- targeted and visible support is being provided to wards by Clinical Governance and the Critical Care Outreach Team;
- the Trust Sepsis Group has been reconvened with a wider clinical membership, including the appointment of senior 'sepsis champions' to support the roll-out of sepsis screening across Medicine and Surgery; and
- we have started to develop and populate with information a dedicated sepsis intranet webpage for staff.

During 2017/18, the Trust will consolidate and embed improvements around sepsis recognition and treatment. Clinical areas will continue to have access to creditable advice and expertise, particularly those wards where performance data suggests they are experiencing difficulties. We will explore new and novel ways to raise awareness and further develop our intranet resources for staff. We will also continue our participation in the Regional Sepsis Group and plan to provide a Trust-wide event in recognition of World Sepsis Day on the 13th September 2017.

3 Reduction in the number of avoidable (predictable) cardiac arrests

Nationally it has been shown that two thirds of all cardiac arrests are predictable events. A recent review into deaths across England (National Confidential Enquiries into Patient Outcomes and Death – Time to Intervene?) showed there was often a failure to assess, recognise and respond adequately to those patients whose condition deteriorates. The

report's main conclusions were that care should be focused on preventing cardiac arrests, through appropriate management of acutely ill people, to maximise their chance of recovery. This priority has focused on improving Trust implementation of National Early Warning Score (NEWS) and management of the deteriorating patient.



The graph shows the number of cardiac arrest calls made and those that were false cardiac arrest calls. False cardiac arrest calls are those patients who were either not for active resuscitation (DNACPR decision was already made) or did not suffer a genuine cardiac arrest. There was a noticeable decline in the number of cardiac arrest calls during the year 2016 as well as the number of false calls.

For 2017 the figures are only up to the end of March.

In an attempt to reduce the number of avoidable cardiac arrest calls, the Trust has:

- encouraged staff to recognise deterioration of a patient by utilising NEWS (a guide used by staff to quickly determine the degree of illness of a patient);
- incorporated NEWS into immediate and advanced life support training;
- trained staff to assess critically ill patients using an airway, breathing and circulation approach to recognise and treat life threatening problems; and
- ensured that all clinical staff attend annual training to a minimum of basic life support.

The incidence of cardiac arrests attended by the Trust Cardiac Arrest Team per 1000 hospital admissions for the year 2015/16 was 1.45 and the target for a 5% reduction was 1.37. In the 1st Quarter 2016/2017 the Trust exceeded this target and achieved a rate of 1.35; however it then increased to 1.70 in the following Quarter (Source – National Cardiac Arrest Audit NCAA). The overall resuscitation training compliance rate for Quarter 3 2016/17 for clinical staff is 84% which increased to 86% in the last Quarter of the year.

The Trust will continue to participate in the NCAA to enable us to benchmark against other trusts in the UK. This will also help in scaling up any improvements. We will also target simulation training for acute clinical staff to include NEWS and recognition of the seriously ill patient.

Other Information - Reducing Healthcare Associated Infection

The Infection Prevention and Control Team (IPCT) have continued throughout this year to drive strategies which promote a zero tolerance for preventable infection.

For a further year the target set by the Department of Health for 2016/17 remained zero for MRSA bacteraemia. This has proven to be another significant challenge for the organisation. Despite continued efforts with improving hand hygiene, asepsis, and surveillance and responding to learning points from investigations, we have reported 5 cases of healthcare associated bacteraemia which is an increase on last year's figure (3 cases 2015/16).

The IPCT continue to work closely with directorate teams to complete a detailed root cause analysis of each case of MRSA bacteraemia. Where lessons have needed to be learnt, these have been shared throughout the organisation, for example, ensuring staff consistently complete intravenous device assessment, reducing the incidence of contaminated blood culture samples, and reminding staff to document the clinical reasons when patient cannulaes are left insitu longer than 72 hours. We will continue to drive improvement in these areas via our Healthcare Associated Infection (HCAI) Plans, with particular emphasis on best practice in the management of intravenous devices.

The target for *Clostridium difficile* infection (CDI) set by the Department of Health remained at 34 Trust apportioned cases. The total number of positive toxin tests reported externally for City Hospitals in 2016/17 was 29. Following detailed examination of each case we have agreed via the appeals process with Sunderland CCG that 9 of these were not genuine infection or infections developing in hospital. Therefore, the Trust apportioned cases is confirmed at 20 against the target of 34 cases which represents a 33% reduction compared to last year. Despite this achievement we continue to identify some recurrent themes, for example; delays in submission of samples, delays in isolation of patients with suspected infection and failure to consistently complete the Bristol stool chart. These areas form part of our HCAI Plans so that the organisation is focused on the appropriate infection prevention measures.

The IPCT can report a number of achievements during 2016/17, which include:

- the continued use of total room decontamination with hydrogen peroxide vapour (a treatment know to be effective at reducing hospital infection). We have also introduced another infection control measure using ultraviolet light;
- increased screening of high risk patients who may have *C. difficile* colonisation;
- continued review and analysis of antimicrobial prescribing with particular reference to the 2016/17 antimicrobial stewardship CQUIN targets;
- increased engagement by IPCT staff with wards, departments and directorates;
- the development of an IPC dashboard to monitor the success of infection control in the hospital;
- the introduction of root cause analysis for E. coli bacteraemia related to urinary catheters;
- our significant contribution to the Trust flu vaccination programme;
- the introduction of cleanliness audits in outpatient areas; and
- the development of a multidisciplinary group to inform strategy for the management of intravenous devices.

Some of the key areas that the IPCT will be involved with next year include; carrying out monthly cleanliness audits in high risk clinical areas, assessing compliance with IV devices, developing a care pathway for the management of the patients with diarrhoea, enhancing surveillance of the Bristol stool chart and undertaking a review of medical staff training for aseptic technique. The IPCT will remain committed to driving the strategies which promote safe, effective infection prevention and control practices across the Trust. The IPCT will also continue to work closely with clinical staff to inform and deliver a robust strategy for the management of infection outbreaks and serious infections.

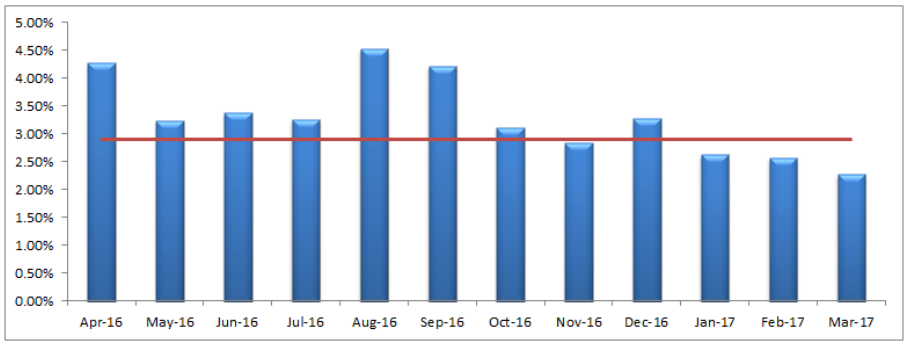
Indicators for improvement — Focusing on Patient Experience

1	**Reducing cancellations of outpatient consultations**
2	**Improve the timeliness of response to patient complaints**
3	**Increase the % of patients who reported they had a positive experience (Q72 - Overall……..)**

1 Reducing cancellations of outpatient consultations

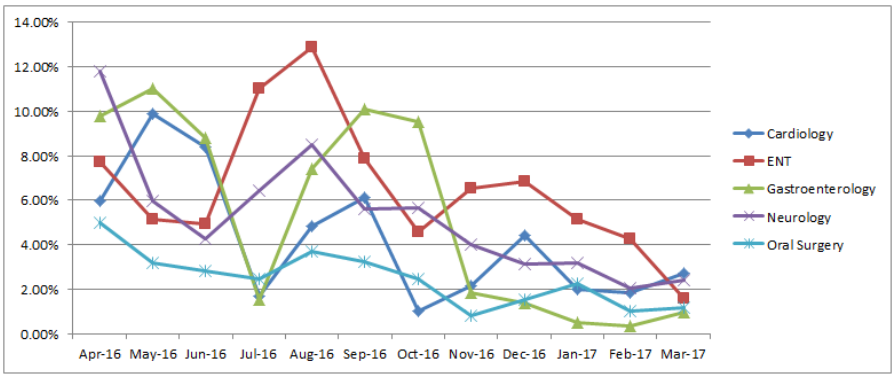
Reducing the number of outpatient appointments which are cancelled is a key quality priority for the Trust. This priority was developed in response to feedback from Trust Governors in order to reduce those cancellations which negatively impact patients. We do acknowledge that some cancellations will be required i.e. to move patients to a more appropriate service for their needs. Reducing cancellations is part of the Trust's improvement programme around scheduling which ensures we provide efficient and effective outpatient services. The baseline cancellation rate was 3.21%, with a target set for a 10% reduction in 2016/17 i.e. 2.89%.

Performance at Trust level for the 12 month period April to March is shown in the graph below. Increases in cancellations in April, August, September were due to issues such as staff sickness, annual leave, and Doctor availability (registrar). We have seen an improvement in our performance to below target for the last 3 months of the year which is extremely encouraging.



There has been a focus on ensuring that clinical teams proactively plan for any reductions in capacity with demand and capacity models now in place for the majority of specialties. It is now easier to see further ahead and plan to increase appointments when required to ensure minimal impact on the service and patients. This should reduce the number of cancellations due to annual leave and staff training. However, the national consultant contract only requires 6 weeks' notice to be given by consultants and some services have longer waiting times therefore it is more challenging to avoid cancellations in these services.

The specialties with the largest improvement in their cancellation rate over the year is shown below.



Further improvement actions in 2017/18 are:

- Monthly analysis is provided to Divisional General Managers, Directorate Managers and Scheduling Managers to identify the reasons for cancellations to inform actions.
- We are looking at ways to ensure there is capacity to accommodate patients when they cancel or when the hospital cancels to ensure they are given a further appointment in a reasonable timescale.
- We look at outpatient appointment cancellations in under 6 weeks for this measure as this is the point at which we send letters to patients to confirm their appointment. As previously indicated, many cancellations are due to unforeseen circumstances such as sickness. , patient booked outside of the e-referral system, reason not specified and no Dr available (registrar). If a patient books their appointment through the NHS e-Referral system (previously Choose and Book) and this is then cancelled, often the cancellation reason recorded is 'booked outside of the e-referral system'. We do know that this is not the primary reason for the cancellation and it is used where the cancelled appointment cannot be re-booked in the e-referral system due to capacity issues. Recently, administrative processes have been reviewed and refined so that the actual reason for the cancellation is recorded. This will improve our analysis and ability to take appropriate remedial action.

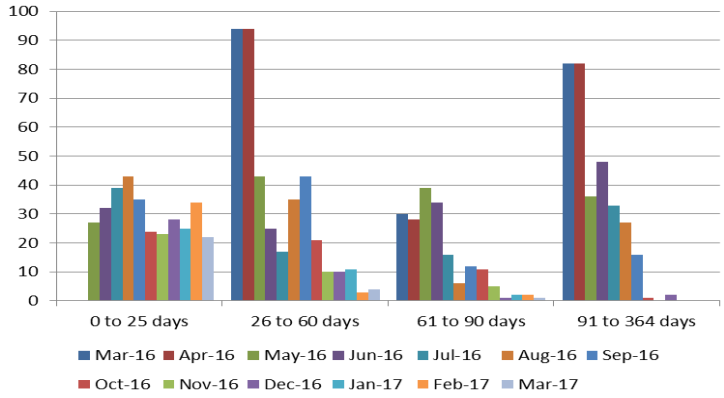
This indicator has been reviewed by our external auditors who have provided feedback in a private report to the Council of Governors.

2 Improve the timeliness of response to patient complaints

City Hospitals provides a comprehensive range of services for thousands of people every day and we know we get it right most of the time. However, we recognise that there may be occasions when things go wrong and patients and

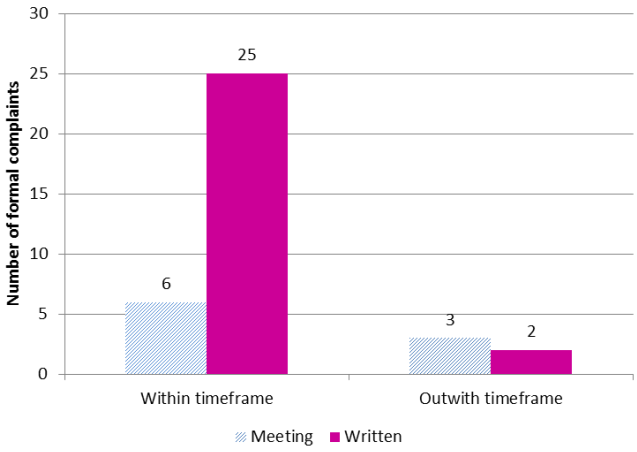
their families may not be entirely satisfied with the level of service they have received. The Trust has an established complaints handling policy in line with the Department of Health's NHS and Social Care Complaints Regulations. In 2015, we introduced the 'Help and Advice Service' which provides support to resolve both formal and informal concerns and this has resulted in a year on year reduction in formal complaints. However, we have not always been able to respond to our complaints in a timely manner and we know that this delay can cause frustration among families.

Formal complaints - working days awaiting first written response



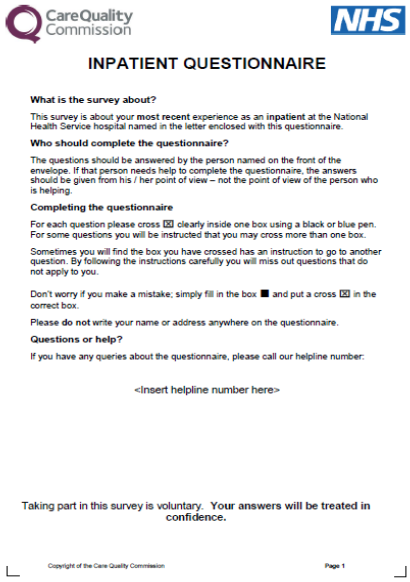
In April 2016, prior to the significant upgrade of the Trust's complaints management system (Ulysses Software System), there was no mechanism to measure against the policy response times, however a number of reports were developed to provide visibility of response times, and progress over the year can clearly be demonstrated. The chart below shows the substantial improvements made to the response time of complaints over the financial year. At the beginning of 2016/17, there were 82 complainants that had waited over 91 days for a first written response. By the end of March 2017, this was zero, with only one complainant waiting more than 61 days. This is a significant improvement in our complaints handling during 2016/17.

All complaints awaiting first response: written or meeting



At the end of March 2017, there were only 5 complaints awaiting a first response, demonstrating significant improvements in the process and far exceeding the 20% improvement target.

3 Increase the % of patients who reported they had a positive experience (Q72 - Overall……..)



CareQuality Commission NHS

INPATIENT QUESTIONNAIRE

What is the survey about?

This survey is about your **most recent** experience as an **inpatient** at the National Health Service hospital named in the letter enclosed with this questionnaire.

Who should complete the questionnaire?

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his / her point of view – not the point of view of the person who is helping.

Completing the questionnaire

For each question please cross ☒ clearly inside one box using a black or blue pen. For some questions you will be instructed that you may cross more than one box.

Sometimes you will find the box you have crossed has an instruction to go to another question. By following the instructions carefully you will miss out questions that do not apply to you.

Don't worry if you make a mistake; simply fill in the box ■ and put a cross ☒ in the correct box.

Please **do not** write your name or address anywhere on the questionnaire.

Questions or help?

If you have any queries about the questionnaire, please call our helpline number:

<Insert helpline number here>

Taking part in this survey is voluntary. **Your answers will be treated in confidence.**

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The national survey of adult inpatients is one of the biggest surveys of its kind and is well established and trusted in the NHS. The aim of the survey is to understand more about patient experiences whilst receiving their care in hospital. It also helps us focus on the right issues as perceived by patients themselves.

The Quality Report has previously shown where we have acted on the results from this survey and made changes and improvements to our service. One of the concluding questions in the survey is about the patients overall rating of their stay in hospital. We wanted to increase the percentage of patients who rate their care at the Trust as excellent, very good or good so that we achieve one of the highest composite scores in the North East.

The field work for the 2016 survey is complete and we are waiting for the national release of the results and how we benchmark against our peers. Individual hospital survey reports are normally available in the Spring.

Other Information - National Patient Surveys

The thoughts, opinions and observations of patients and relatives who use our hospital services are very important to us. Our aim is that every patient's experience is a positive one and understanding what matters most for them and their families is a key factor in achieving this. We collect patient feedback in many different ways, including local patient experience questionnaires and through the Friends and Family Test and alongside this we also take part in the annual National Patient Survey Programme. These mandatory surveys allow us to compare our performance with other Organisations and, equally as important, it allows us to see whether any actions we have taken in response to previous surveys have actually improved our services.

For 2016/17 City Hospitals participated in the following national patient surveys;

Type of survey	Data collection
Children & Young People's Inpatient and Day Case Survey 2016	Jan – June 2017
Emergency Department 2016	Oct 16 – March 17
Cancer Patient Experience Survey 2016	Oct 16 – Feb 17
Adult Inpatient Survey 2016	Aug 15 – Jan 17

The later than usual publication of the 2015 adult inpatient survey meant that we were not able to include the results in last year's Quality Report. Therefore, we include a summary of our performance below with the full benchmarking report available from the following link, (http://www.nhssurveys.org/Filestore/Inpatient_2015/BMK%20reports/IP15_RLN.pdf).

National Patient Survey Programme

Adult Inpatient Survey 2015

We asked patients about their most recent hospital stay

The Adult Inpatient Survey gives patients the opportunity to give their views about their most recent stay in hospital. The questionnaire asks for feedback on a number of topics such as admission, contact with doctors and nurses, privacy and dignity, cleanliness, hospital food and their involvement in discharge planning. The results are used to identify and drive improvements where it is felt necessary. In total 657 patients gave their opinion on the care and service provided by City Hospitals. This was a higher response rate than in previous years and was due to changes in the sampling methodology where the size of the patient sample drawn increased from 850 to 1,250.

The table below provides an aggregated score for questions grouped according to the sections in the inpatient questionnaire. A higher score is better. Each Trust is also assigned a category, to identify whether their score is

better, about the same, or worse than most other Trusts who carried out the survey. City Hospitals achieved an 'about the same' rating for each of the 11 sections compared with other Trusts. The public can view this section table on the Care Quality Commission website (http://www.cqc.org.uk/provider/RLN/survey/3) and drill down in individual questions under each section theme.

Score	Section themes	Rating compared with other Trusts
8.7/10	The Emergency Department / A&E Department	WORSE / ABOUT THE SAME / BETTER
8.9/10	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
8.2/10	The hospital and ward	WORSE / ABOUT THE SAME / BETTER
8.7/10	Doctors	WORSE / ABOUT THE SAME / BETTER
8.5/10	Nurses	WORSE / ABOUT THE SAME / BETTER
7.9/10	Care and treatment	WORSE / ABOUT THE SAME / BETTER
8.4/10	Operations and procedures	WORSE / ABOUT THE SAME / BETTER
7.2/10	Leaving hospital	WORSE / ABOUT THE SAME / BETTER
5.5/10	Overall views of care and services	WORSE / ABOUT THE SAME / BETTER
8.1/10	Overall experience	WORSE / ABOUT THE SAME / BETTER

The results show that across the 63 questions which measure our performance from the patient's perspective, 62 (98.4%) were rated in the amber 'expected range' category, meaning that we are about the same as most other Trusts in the survey. There were no questions in the red or 'worse' performing category but the Trust did have 1 question rated as green or 'better' than other Trusts; this was related to shorter delays for patients being discharged home.

Areas where the Trust improved and achieved the largest increase in individual scores compared to the last survey in 2014:	Areas where the Trust failed to increase its individual scores compared to the last survey in 2014:
• Cleanliness of the toilets and the bathrooms that were used in the hospital; • Patients were given answers to questions that they could understand; • Patients felt that they were given enough notice about when they were going to be discharged; • Staff explained the purpose of the medicines patients were going to take home in a way that they could understand;	• Patients felt that they did not get enough help from staff to eat their meals; • Hospital staff did not tell sufficient patients about danger signals to watch out for after they went home; • On occasions, hospital staff did not discuss with patients about whether they needed any further health or social care services after leaving hospital; • Patients felt that some hospital staff did not do everything they could to help control their

• More patients rated their hospital food; • The anaesthetist and other members of staff explained to patients how they would be put to sleep or have their pain controlled; and • Staff did discuss with patients what additional equipment or adaptations were needed at home.	pain; and • Hospital staff did not tell sufficient patients about medication side effects to watch for when they went home.

The results of the national adult inpatient survey has been shared with staff and presented to key internal groups, including the Patient, Carer and Public Experience Committee; they are responsible for ensuring that actions for improvement are undertaken and reported.

National Patient Survey Programme

Cancer Patient Experience Survey 2015

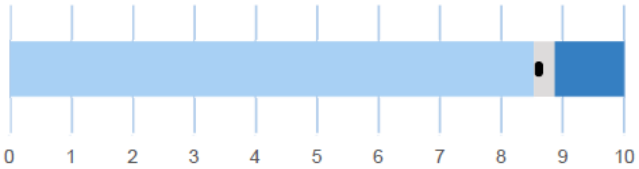
We asked patients about their experiences of our cancer services

The National Cancer Patient Experience Survey is an annual survey which asks cancer patients specific questions about their experience in hospital Trusts in England. The aim of the survey is to measure patient satisfaction and experience, and provide important information for Trusts to improve their cancer services. The survey included all adult patients (aged 16 and over) admitted as an inpatient or day case with a primary diagnosis of cancer in the months of April, May and June 2015. In total, 806 eligible patients were invited to participate in the survey and 482 completed questionnaires were returned, representing a response rate of 65%, (56% last year so a 9% increase).

The survey consisted of 50 questions where patient experience could be measured. In view of the fact that a number of significant changes were made to the 2015 survey, we are unable to directly compare data from the 2015 survey to the findings of previous surveys.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), patients who responded to the survey gave an average rating of **8.6**.

Q59 Patient`s average rating of care scored from very poor to very good



The following questions are also included in phase 1 of the Cancer Dashboard which is developed by Public Health England and NHS England:

- **78%** of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment,
- **94%** of respondents said that they thought the GPs and nurses at their general practice would support them through their treatment,
- when asked how easy or difficult it had been to contact their Clinical Nurse Specialist **91%** of respondents said that it had been 'quite easy' or 'very easy',
- **82%** of respondents said that, overall, they were always treated with dignity and respect while they were in hospital,
- **95%** of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital, and
- **61%** of respondents said that hospital staff definitely did everything they could to support them while they were having cancer treatment

The table below lists the questions which are scored outside the 'expected range'; the range of scores that would be expected for Trusts of the same size. Those questions rated as higher than expected (which is good) are in dark blue and those which are lower than expected (requires improvement) in pale blue. The table also shows the upper and lower limits as well as the national averages.

Question		Number of respondents for this Trust	2015 Case-mix Adjusted			
			2015 Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	National Average Score
Deciding the best treatment for you						
Q15	Patient definitely told about side effects that could affect them in the future	429	59%	50%	59%	54%
Clinical Nurse Specialist						
Q17	Patient given the name of the CNS who would support them through their treatment	459	94%	86%	93%	90%
Hospital care as an inpatient						
Q34	Always given enough privacy when discussing condition or treatment	297	80%	81%	89%	85%
Q37	Always treated with respect and dignity by staff	297	82%	84%	91%	87%
Hospital care as a day patient / outpatient						
Q44	Beforehand patient had all information needed about radiotherapy treatment	83	78%	78%	93%	86%
Home care and support						
Q51	Patient definitely given enough support from health or social services after treatment	185	52%	38%	52%	45%
Your overall NHS care						
Q55	Patient given a care plan	383	42%	27%	39%	33%

As in previous years the key findings from the survey are presented to the Patient, Carer and Public Experience Committee and action plans are developed for each of the cancer site multidisciplinary teams.

The full set of results from the Cancer Patient Experience Survey 2015, published in July 2016, can be found from the following link http://www.ncpes.co.uk/index.php/reports/local-reports/trusts/3135-rln-city-hospitals-sunderland-nhs-foundation-trust-2015-ncpes-report/file

Our new local 'Patient Experience Survey'

During 2016 we introduced changes to the existing Friends and Family Test and Real Time Feedback data collections. Both these processes were separate but we decided to combine them and create a new Patient Experience Survey (see image of the new front page design) for our adult inpatient services. The changes did not apply to our Outpatient Department, Maternity Services, Paediatric Wards or our Intensive Care Unit and they will continue to use separate real time feedback questionnaires and the FFT postcards. However, we will look to see whether these areas move to the new format during 2017.

For all adult inpatients, at the point of discharge, they are now offered a short survey which combines the questions from the real time survey and the Friends & Family Test question. A free text option is still available within the new design to enable patients to add any further positive or negative comments.

The surveys are completed by patients themselves, posted in a collection box on the ward and analysed in-house. Staff can give patients help and support if required. Wards are sent monthly reports highlighting their results, which include transcriptions of any free text comments. The results are also included in ward performance dashboards and are viewable to the public.

The graphic below shows the total number of completed surveys received for each type of patient experience collection. For 2016/17 the Trust has received nearly 10,000 questionnaires which is more than double last year (4032). This is a substantial increase to the Trust-wide collection and provides a huge amount of intelligence about the patients' stay in hospital.

PATIENT EXPERIENCE COLLECTIONS 2016/17						
	'Patient Experience Survey'	Maternity 'Real Time Feedback'	Paediatrics (Parents) RTF	Paediatrics (Child) RTF	Neonatal Real Time Feedback	ICCU RTF
April 2016 – March 2017	8422	410	343	207	130	90
TOTAL = 9602						

High level summaries of the patient experience, on a ward by ward basis, together with 'word cloud' illustration of any free-text comments are presented at the Patient, Carer and Public Experience Committee. Each ward also receives their own monthly report to share with their staff. The aggregated data is also shared with our Commissioners as part of information exchange and assurance.

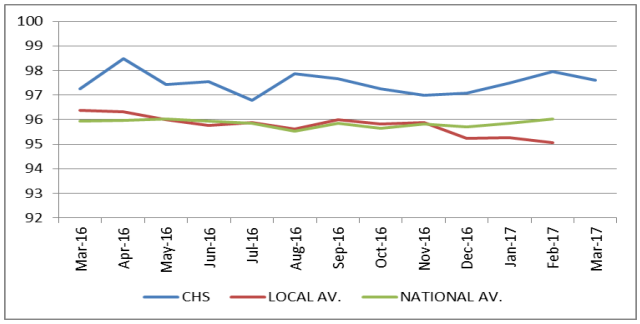
Friends & Family Test

The Friends & Family Test (FFT) gives every patient the opportunity to provide feedback on the services they have received, and enables the public to make better informed choices about the services they use. The FFT now includes all our inpatient wards, including children and maternity, out patients, day cases and our GP Practice, Church View Medical Centre. As previously mentioned the process for administering the FFT system has recently changed for the adult inpatient areas. The charts below show the patient scores (as a measure of whether they would recommend the hospital to family and friends) achieved in 2016/17 for selected areas, with many showing performance above the national and local averages.

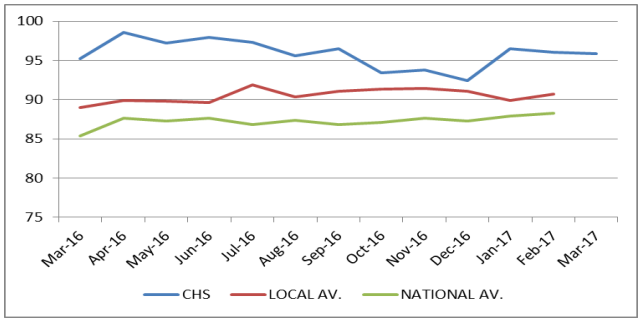
Response rates within ED remain low however the recommended rate remains high and above national average. The patient experience team have worked with the ED team to improve response rates in the past this included identifying FFT champions, displaying the FFT scores and patient free text comments in the main corridors, increasing the numbers of FFT post boxes, increasing the visibility of FFT communications /literature/posters for both patients and

staff. This focussed work with the teams was put on hold when the ED moved into temporary premises, however work with the teams will recommence once the new ED opens

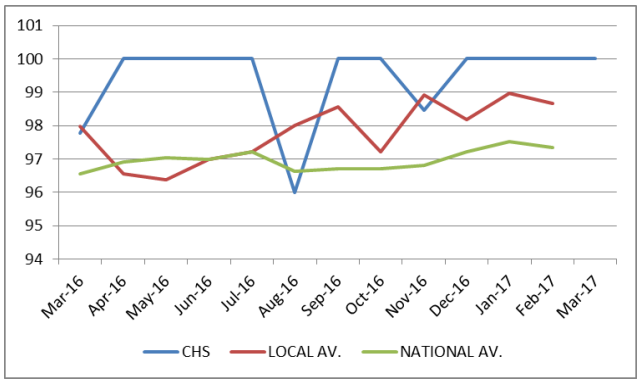
Friends & Family Test - Inpatient score



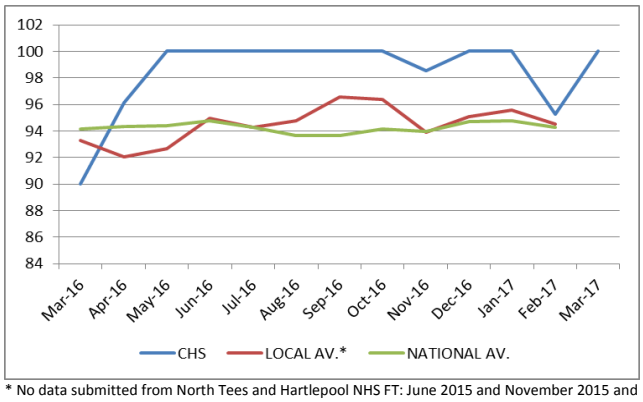
Friends & Family Test – Emergency Department score



Maternity Q2 – Labour Ward

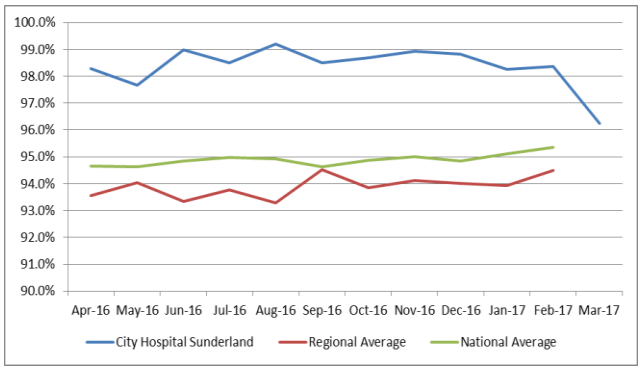


Maternity Q3 – Postnatal ward

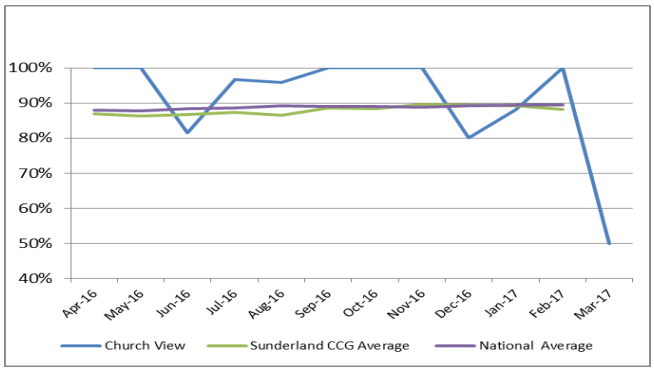


* No data submitted from North Tees and Hartlepool NHS FT: June 2015 and November 2015 and South Tyneside NHS FT: May 2015 and January 2016

Outpatients - % recommended



Church View Medical Centre (GP) - % recommended

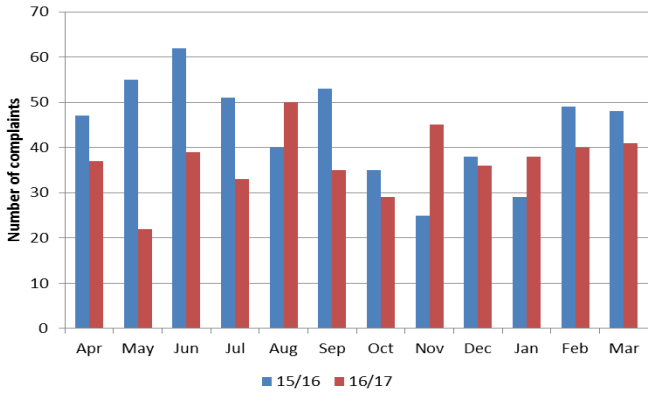


Complaints

The Trust has an established complaints handling policy in line with the Department of Health's NHS and Social Care Complaints Regulations. This policy confirms that the Trust has a robust system in place to allow patients (or their nominated representative) the opportunity to have their concerns formally investigated and to receive a comprehensive written response from the Chief Executive.

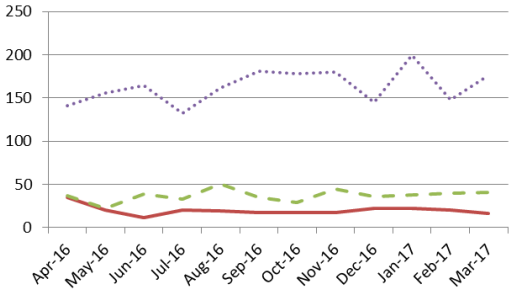
The Trust welcomes both positive and negative feedback from our patients as a contribution towards improving the services we deliver. To ensure that the Trust is learning from experience, a Complaints Report is submitted each month to the Patient, Carer and Public Experience Committee regarding complaints activity. This data is also included in the Trust Quality, Risk and Assurance Report which is presented to the Governance Committee. Themed complaints are considered by the relevant organisational group for example, End of life, Dementia, etc., this enables the Trust to identify and monitor trends and themes, and ensure organisational action to reduce the risk of recurrence.

Formal complaints received by month (April 16- March 17)



The table opposite shows that there were 445 formal complaints received in 2016/17, an average of 37 per month. In 2015/16 there were 532 formal complaints received, an average of 44 per month, demonstrating a 20% reduction this year.

All types of feedback received (April 16 – March 17)



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Compliments	35	20	11	20	19	17	17	17	22	22	20	16
Formal	37	22	39	33	50	35	29	45	36	38	40	41
Informal	141	156	164	132	161	181	178	180	145	199	148	176

The chart opposite includes all feedback; compliments, formal and informal complaints. In 2016/17 there were 1961 informal concerns received by the Help and Advice Service, a 10% increase on the 1775 received in 2015/16. There were 236 compliments recorded but it is recognised that many compliments received are not recorded.

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.

What Patients / Carers Said	Changes We have Made
They wanted to be more involved in supporting the person they care for whilst in hospital (*Carers*)	We introduced a carers' passport, which provides carers with information that reinforces John's Campaign; that they can visit outside of core visiting hours, including staying overnight if appropriate
Sometimes information leaflets are not easy to understand for patients with communication difficulties	We worked with local people with Learning Disabilities to develop a range of easy read leaflets
They were not always clear about plans for discharge	We have implemented "Red and Green Days" across the Division of Medicine to support the smooth management of a patient's medical care plan, including discharge planning. Red and Green Days is a simple visual management system to assist in the identification of delays in a patient's journey. The initiative aims to ensure patients get the appropriate interventions, diagnostics, specialist opinions and discharge planning without delay
They miss their pets when in hospital	For some time, Buster the dog and Julie, his volunteer handler have been visiting the Stroke Unit (E58). In 2016/17 we recruited two more the Pets as Therapy (PAT) dogs and their owners
They received too much information at the time of diagnosis, and this was often difficult to take in and understand (*Head & Neck Cancer patients*)	Before patients start their treatment they now attend a nurse led clinic to discuss their treatment journey and potential side-affects

When their baby died in the Maternity Unit they felt the environment was unsuitable	We are now developing a purpose built bereavement suite
That because it was difficult for him to communicate with staff, they did not always understand information about him as an individual person (*Stroke patient*)	The Stroke Unit have installed "All about me" visual boards above the patient's bed. The boards are completed by the patient (if able) and their family members, and include personal information such as likes and dislikes, occupation and family information. This helps the staff to get to know the patient on a personal level
They were worried that their elderly relatives were not eating enough whilst in hospital (*from families*)	We know that many patients, especially the elderly, lose their appetite whilst in hospital. One of our Care of the Elderly wards introduced a snack round, in addition to the usual meal times, offering all patients a choice of high calorie snacks such as scones, fruit, cakes, cheese and crackers, biscuits, thick and creamy yoghurts, jelly, and fortified milk to drink
They often feel depressed, and can have low self-esteem following cancer treatment (*cancer patients*)	Our Macmillan Centre has worked with Look Good Feel Better, an international charity, to establish workshops for our cancer patients. The workshops, supported by trained beauty therapists from local shops, help women combat the visible side effects of cancer treatment. This support improves the wellbeing of women receiving cancer treatment
They could not get through to the outpatient department to cancel/amend their appointment	In response, we have extended the opening times of our call centre to 7pm Monday to Friday and Saturday mornings. We have increased the number of staff on duty at the call centre to ensure all patients calls are answered promptly. We have also introduced a system where patients can cancel or reschedule their appointment electronically
The experience was very frightening and intimidating for their family member who has learning disabilities. This resulted in them displaying their anxiety as agitation, and aggression, which resulted in unpredictable behaviour (family carer of a patient who attended the Day of Surgery Admission Unit)	In response to this experience, the Day of Surgery Admission Unit has made a number of changes, including; • Specific arrival times; • Trolleys and non-essential medical equipment are now removed from rooms; • Rooms are decorated with personal pictures; • I pod is available to play personal and favourite music; • Depending on the surgical procedure, patients may wear their own clothes rather than changing into a theatre gown; • Carers are able to remain with patients and accompany them to theatre if necessary and are with them when they wake up; • Patients may walk to theatre instead of going on a trolley or chair; • Post-operative medication and discharge documentation is made available immediately post-surgery; and • Same nurse allocation if a return visit is necessary.

Help and Advice Service

The City Hospitals Sunderland Help and Advice Service is an easily accessible service for families, providing support to resolve both informal and formal concerns in a timely way and hopefully reduce the number of complaints. The service incorporates the previous PALS and Complaints Service but also brings a new "customer care" approach to our patients and their families.

The service is open Monday to Friday between 8.00 am and 5.00 pm supported by volunteers who are able to assist the public with general enquiries, including signposting them to wards/departments, offering relevant information leaflets or escalating any concerns to the Help and Advice Service Assistants.

If a concern cannot be resolved by the Help and Advice Service Assistants or the wards or departments, then the situation will be managed as a formal complaint by the Help and Advice Service Co-ordinators.

During 2016/17 there were 1961 informal concerns received by the Help and Advice service, a 10% increase on the 1775 received in 2015/16. There were 236 compliments recorded, however, it is recognised that many compliments received by the Trust are not recorded.

Carers

City Hospitals is committed to giving carers the recognition, involvement opportunities and support necessary to improve the experience of the many patients and carers who have access to our services. A carer is someone who, without payment, provides help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability. Some of the carer related initiatives and activities that the Trust has been involved with during 2016/17 include:

Carers' Week 6-12 June 2016 - as part of the Carers Week celebrations, in partnership with Sunderland Carers' Centre, we held a carers coffee morning in our Education and Training Centre. The event was supported by other agencies such as The Stroke Association, Age UK, CHS Carer Co-ordinator, Macmillan services and the Independent Living Centre. Unfortunately only a small number of carers were able to come along however the event was well attended by Trust staff, which increased their awareness of the needs of carers and those staff who have caring responsibilities.

Sunderland Safe Place Scheme - Carers of adults with learning disability told us of concerns they had when the person they cared for faced difficulties when they were unaccompanied and about a "Safe Place Scheme" which had been developed to address this. The scheme provides vulnerable adults with a safe place to visit if they are alone and feel worried, concerned, bullied or lost. This programme is currently being rolled out across the City of Sunderland, including City Hospitals and is also supported by Northumbria Police. The reception areas in the hospital have been identified as "safe place" areas and designated stickers are now displayed. Staff awareness sessions have been provided by Sunderland People First, a self-advocacy group for people with learning disabilities

Volunteers

Volunteers play an important role delivering our services and we know their hard work and friendliness enhance the patient and family/carer experience at City Hospitals. Our volunteers are not directly involved in patient care but help provide extra support to patients and staff and we are extremely grateful for all the support we receive. There are a number of reasons why people volunteer. For many it is a chance to do something positive and to help others. For others they simply have time to spare that they wish to give to something that matters to them. City Hospitals actively encourages local people to volunteer their time and talents for the benefit of our patients, staff and visitors. Volunteering can be very rewarding and can be used to develop new skills, confidence and meet new friends

We had a successful recruitment drive in early 2016 in order to increase our team of volunteers and hope to repeat the process later this year. All volunteers are asked to commit to at least one 2 hour shift per week and to engage in volunteer roles on a regular basis for a minimum period of 6 months. Some of the roles undertaken by our current hospital based volunteers include; helping vulnerable and frail patients on wards, acting as 'hospital navigators' to make sure visitors can get to the right place in time and supporting the work within the Help and Advice Service. Other volunteering opportunities exist within the Chaplaincy and the Macmillan Services. A number of our volunteer team have been actively involved in the PLACE inspections this year as well as participating in the Trust Nutrition & Hydration Week helping to serve afternoon tea to patients.

Patient-Led Assessment of the Care Environment (PLACE)

PLACE provides an annual snapshot to organisations of how their environment is seen by those using it, and provides insight into areas for improvement. The assessments focus on how the environment supports service provision and patient care, looking at non-clinical aspects such as cleanliness, food, maintenance, as well as the extent to which the environment supports privacy and dignity and compliance with dementia standards.

This round of inspection was the fourth year of PLACE and once again saw a number of changes to the inspection. Whilst most of these were minor, the main changes related to the scoring methods in some of the key categories and the extent to which environments support the care of patients with dementia. A new, sixth PLACE domain looking at disability standards was also introduced for the first time this year.

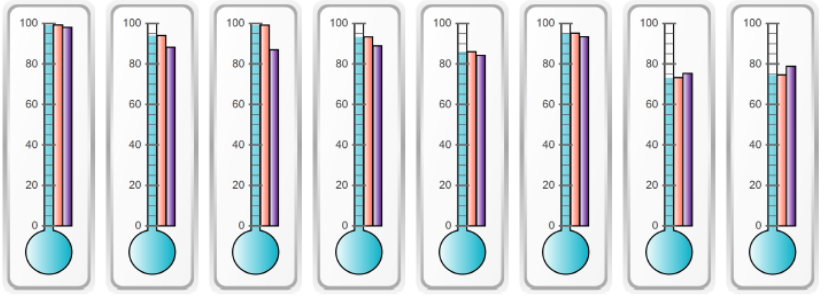
The focus of the annual PLACE inspection is on improvement, with hospitals required to report publicly, and say how they plan to improve. It is seen as complementing the work undertaken by the many other active groups in the Trust, i.e. Strategic Infection Prevention and Control Group, National Standards of Cleanliness Group, Matron & IPC Inspections, Director of Nursing/Non-Executive Director Spot Checks and Facilities Services contract monitoring. Once again the PLACE process benefited from the continued commitment of representatives from the Board of Governors, the Trust Community Panel and Sunderland Healthwatch.

The PLACE process is designed to recognise the age and nature of the buildings that contribute significantly to the patient environment, and this was particularly evident when comparing some of the Trusts newer, purpose built wards with the older areas. It was evident that the focus over recent years has been on the refurbishment of inpatient ward areas with some of the outpatients areas visited looking slightly tired looking and in need of renewal and some redecoration.

Due to the detailed and diligent approach of the inspection teams, a number of issues were identified, as would be expected from a very busy working environment, although none of the issues noted presented any immediate impact on the quality of the patient experience. In many cases, the issues identified were temporary incidents, due to daily routine activity, with arrangements already in place to resolve them.

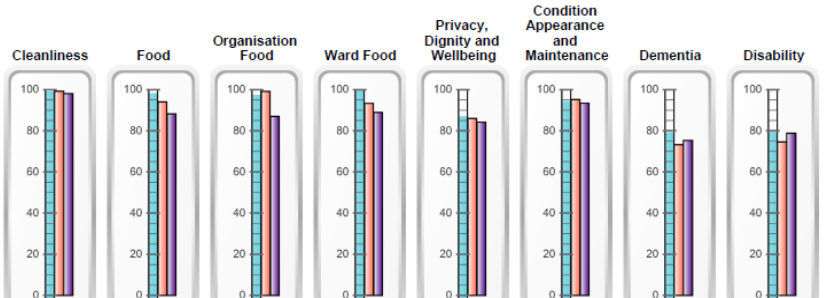
The results for both the Sunderland Royal Hospital and Eye Infirmary site show continued strong performances against national averages with only the dementia and the new disability domains slightly below the national average thresholds. Similarly when compared against our local Trusts we do particularly well. The tables below show the scoring for the Sunderland Royal Hospital and Eye Infirmary sites against the national averages:

SUNDERLAND ROYAL HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	6346.0000	874.0206	113.6426	760.3780	660.4999	3022.0000	1316.9117	800.4243
Available Score (Actual)	6396.0000	930.2013	114.5880	815.6133	768.0000	3174.0000	1800.8571	1074.3697
Site Score	99.22%	93.96%	99.17%	93.23%	86.00%	95.21%	73.13%	74.50%
Organisation Average	99.22%	94.02%	99.15%	93.32%	86.02%	95.20%	73.21%	74.57%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

SUNDERLAND EYE INFIRMARY- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	665.0000	170.9871	111.6426	59.3445	115.0000	402.0000	253.9117	165.4243
Available Score (Actual)	670.0000	173.9325	114.5880	59.3445	132.0000	426.0000	320.8571	208.3697
Site Score	99.25%	98.31%	97.43%	100.00%	87.12%	94.37%	79.14%	79.39%
Organisation Average	99.22%	94.02%	99.15%	93.32%	86.02%	95.20%	73.21%	74.57%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

Source: Health and Social Care Information Centre

The findings from the PLACE inspections have been shared with Divisional General Managers at the Operational Management Group, and cascaded to their teams. The report has also been discussed with the G4S Domestic Team and Facilities are working with G4S to establish a follow up action plan, focusing on cleaning and environmental issues. Action is already underway on those areas of particular urgency, with follow-up visits by IPAC and the Domestic Monitoring Team, working closely with individual wards. The multi-disciplinary Trust National Standards of Cleanliness Group was the key overarching group identified to drive forward specific actions identified for individual wards and departments as well as Trust-wide issues.

Part 3.2 Performance against key national priorities 2016/17

Performance against National Measures

During 2016/17 the Trust has continued to achieve national operational and quality standards across a number of key measures (as shown below), including waiting times for cancer and consultant-led treatment, ensuring patients admitted to hospital are assessed for risk of developing a blood clot (VTE) and reducing the number of hospital acquired healthcare infections year on year.

Some of these indicators are taken into consideration by NHS Improvement, the regulator of Trusts, as part of their regular assessment of governance.

For some indicators the Trust was below the standard set for 2016/17. However, across a number of indicators there has been an improvement (or reduction dependent upon the specific indicator) from the previous year, including waiting times for consultant-led treatment, all cancer waiting time indicators, incidence of *C. difficile*, appointment capacity available on the national e-Referral system and timely communication to patients and GP practices following an inpatient stay, A&E or outpatient attendance.

Indicator	Last Year 2015/16	Target 2016/17	2016/17	Variance	Year
National Operational Standards					
Referral to Treatment waits % incomplete pathways waiting less than 18 weeks[1]	93.82%	92%	94.00%	2.00%	🟢
Diagnostic Test waiting times[1]	0.80%	1%	2.14%	1.14%	🔴
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	93.57%	95%	92.97%	-2.03%	🔴
All Cancer Two Week Wait	94.41%	93%	95.91%	2.91%	🟢
All Cancer 62 day urgent referral to treatment wait	83.10%	85%	84.00%	-1.00%	🔴
62 day wait for first treatment following referral from an NHS Cancer Screening Service	100.00%	90%	100.00%	10.00%	🟢
31 day standard for cancer diagnosis to first definitive treatment	98.48%	96%	98.67%	2.67%	🟢
31 day standard for subsequent cancer treatments - surgery	99.47%	94%	98.40%	4.40%	🟢
31 day standard for subsequent cancer treatments - anti cancer drug regimens	99.88%	98%	99.90%	1.90%	🟢
Cancelled operations not rescheduled within 28 days	13	0	34	34	🔴
National Quality Requirements					
HCAI - MRSA Bacteraemia[2]	3	0	5	5	🔴
HCAI - Clostridium Difficile[2]	30	≤34	20	-14	🟢
VTE risk assessment for inpatient admissions	98.26%	95%	98.50%	8.50%	🟢
Ambulance Handover Delays 30-60 minutes	405	0	1349	1349	🔴
Ambulance Handover Delays 60+ minutes	102	0	381	381	🔴
Duty of Candour	138	N/A	118	N/A	N/A

Local Quality Requirements					
eReferral - % appointment slot issues	7.38%	6%	6.64%	0.64%	🔴
eReferral - % utilisation	88.94%	85%	72.77%	-12.23%	🔴
A&E time to initial assessment (median)	8 mins	9 mins	9 mins	0 mins	🟢
A&E time to treatment (median)	52 mins	60 mins	52 mins	-8 mins	🟢
A&E left without being seen	1.94%	5%	1.94%	-3.06%	🟢
Discharge letters issued in 24 hours	82.02%	95%	86.57%	-8.43%	🔴
Outpatient clinic letters issued <14 days	82.44%	95%	88.06%	-6.94%	🔴
A&E attendance letters issued <24 hours	92.87%	95%	94.51%	-0.49%	🔴
Ambulance diverts and deflections from the Trust	65	N/A	66	N/A	N/A
Ambulance diverts and deflections to the Trust	126	N/A	97	N/A	N/A
Maternity – smoking at the time of delivery	18.41%	≤18%	17.23%	-0.77%	🟢
Maternity – breastfeeding initiation	54.23%	58%	54.35%	-3.65%	🔴
Cancer diagnosed at an early stage	46.44%	60%	51.75%	-8.25%	🔴

[1] Excludes non English commissioners as per NHS England published statistics

[2] Cases apportioned to Acute Trust only. Figure is post appeal process and measures against our nationally prescribed *C. diff* objective.

Referral to treatment (RTT) pathways

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 incomplete RTT pathways waiting less than 18 weeks out of all patients on incomplete RTT pathways at the end of the period;
- The indicator is calculated as the arithmetic average derived from the monthly performance as reported to the Department of Health between April 2016 to March 2017;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led services, which meets the definition of service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

A&E waiting times –total time in the A&E department

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 who spent 4 hours or less in A&E from arrival to transfer, admission or discharge;
- The indicator is calculated as the arithmetic average derived from the monthly performance as reported to the Department of Health between April 2016 to March 2017;
- The types of A&E services included are: type 1 A&E department (a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients), type 2 A&E department (a consultant led single specialty accident and emergency service with designated accommodation for the reception of patients) and type 3 A&E department (other types of A&E/minor injury units (MIUs)/Walk-in Centres (WiCs)/Urgent Care Centre, primarily designed for the receiving of accident and emergency patients, which can be doctor led or nurse led);
- The clock starts from the date and time that the patient arrives in A&E, or for ambulance arrivals, the arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier; and

- The clock stops when the patient leaves the department on admission, transfer from the hospital or discharge.

Accident and Emergency (A&E)

During 2016/17 the Trust has continued to receive an increasing number of patients through our A&E departments with a 6% increase compared to 2015/16 (3% real growth due to an in year counting change). As a result we did not achieve the national standard of 95% of patients spending a maximum of 4 hours in the department. Despite the pressures, performance was about the same as the previous year and was better than the national average. We have remained consistently in the upper middle 25% of Trusts nationally throughout the year. The Trust continues to work with our local commissioners and partners as part of the A&E Delivery Board to provide leadership and focus to improve access to urgent and emergency care services.

We have implemented a number of initiatives which have helped to improve waiting times in A&E such as:

- Ensuring patients are directed to the most appropriate service for their needs including Pallion Health Centre which deals with minor illness and injury and provides access to a GP, and ambulatory care services for patients who may need further assessment and treatment but do not need to stay in hospital;
- Ongoing work to optimise the processes on inpatient wards to ensure timely consultant review and discharge where clinically appropriate to minimise delays; and
- The Trust continues with the new Emergency Department build which will provide increased capacity, improved flow and a high quality environment for patients and is due to open in May/June 2017.

The Trust has continued to perform well against quality indicators such as timely assessment by a clinician, time to treatment from arrival and patients who left the A&E department without being seen. Delivery of the 4 hour standard remains a risk for the Trust as we move into 2017/18.

Cancer Waiting Times

The Trust has continued to achieve the national waiting time standards for the majority of cancer targets. The only standard not met was for patients treated after being referred from their GP. 85% of patients referred from their GP for suspected cancer should receive treatment within 62 days and the Trust was marginally below this standard in 2016/17 due to increasing numbers of referrals. Performance was however consistently above the national average.

Work has been ongoing throughout the year to improve cancer pathways and ensure patients receive timely treatment. We are involved in the local cancer action taskforce group which is overseeing local implementation of the recommendations from the national cancer strategy.

Diagnostic Waiting Times

Unfortunately the Trust did not meet the national standard for patients waiting less than 6 weeks for their diagnostic test. This was due to increasing demand and operational issues in cardiology from December onwards, which meant that some patients were waiting more than 6 weeks for an Echocardiogram (ECHO). This remains a risk during quarter 1 of 2017/18, however plans are underway to improve performance.

Correspondence to patients and GPs

The Trust has continued to improve performance around the standards agreed with commissioners in relation to issuing correspondence after a patient contact with the Trust. This includes an outpatient appointment, A&E attendance or inpatient stay in hospital. During 2016/17 we have introduced different ways for patients to contact us about their appointments including an electronic form on the internet for patients to cancel an appointment if this is no longer required.

Approach to measuring performance – what and how we measure

The Trust measures performance across a wide range of indicators including:

- National indicators, Operational Standards and Quality Requirements – these are set by NHS Improvement, the regulator of Foundation Trusts and NHS England;

- Local Quality Requirements – agreed with commissioners and included in our contract; and
- Internal indicators – these are agreed as part of our annual planning process and KPI's are developed to measure progress against delivery of our corporate objectives

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

- Monthly reporting of activity, waiting list and key performance indicators by Directorate to the Operations Committee, a formal subcommittee of the Board of Directors;
- Detailed monthly reports for divisional general managers, directorate managers and clinical directors; and
- Performance and contract meetings with directorate managers and external meetings with the Clinical Commissioning Groups.

Annex 1: Statement from Coordinating Commissioners: NHS Sunderland Clinical Commissioning Group, NHS Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group, NHS North Durham Clinical Commissioning Group and NHS England.

Sunderland, DDES and North Durham Clinical Commissioning Groups (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 high quality. This responsibility is taken very seriously and considered to be an essential component of the commissioning function. SCCG coordinates commissioning with City Hospitals Sunderland NHS Foundation Trust (CHSFT) on behalf of the other commissioners.

The CCGs would like to thank the Trust for sharing the 2016/17 Quality Report and for the opportunity to comment upon it. We would like to acknowledge the openness and transparency in the work the Trust has achieved to date, in the delivery of the 2016/17 priorities and in the on-going delivery of the quality measures.

Throughout 2016/17 Quality Review Group (QRG) meetings with representation from the CCGs have taken place with CHSFT on a bi-monthly basis. These are a well-established mechanism to monitor the quality of the services provided by the Trust and aim to encourage continuous quality improvement. The QRG has remained sighted on the Trust's priorities throughout the year for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny at the QRG meetings with the Trust.

SCCG, with representation from DDES and NDCCGs, has conducted a programme of clinical quality assurance visits to the Trust in 2016/17. Their purpose is to gain further insight and assurance into the quality of care and experience provided for patients. This has resulted in valuable partnership working with the Trust and given the CCGs the opportunity to make recommendations for suggested areas of improvement to services. The continuation of a programme of CCG visits has been planned and agreed for 2017/18.

There a number of areas where the Trust has made quality improvements in 2016/17 that have been important for patient care. We would like to congratulate the Trust on the implementation of measures to reduce the incidence of Hospital Acquired Pressure Ulcers and note the improvements to date. The CCGs acknowledge the plan for continuous improvement as a priority for 2017/18 and will continue to monitor the Trust's position on this through the QRG alongside the Trust's position documented on the Safety Thermometer.

The CCGs wish to thank the Trust for their openness regarding the issue of mortality and commend the Trust on their clinical engagement and full participation in the national mortality case record review programme and Regional Mortality Group to address this. The Trust's response to the Care Quality Commission mortality outlier alert was robust, with the investigation revealing that no deaths were avoidable however positive improvements were identified and action plans implemented which will reflect in improved patient care and experience. It is positive that the Trust has identified this issue as a priority for improvement and will be encouraged to meet the targeted 80% review of patient deaths using the Mortality Review Panel process and monitored through the QRG.

We would like to commend the work carried out to date with regards to improving the hospital experience of patients with dementia and the implementation of the priorities from the national audit of dementia care within the Trust. The CCGs agree that this continues to be a priority for improvement for 2017/18 and beyond and look forward to receiving updates in respect of this priority at QRG. Furthermore the CCGs would like to acknowledge the Trust's reported engagement in national and local clinical audits and confidential enquiries and look forward to receiving further information on planned improvements and services as a result. Equally the Trust is congratulated on its proactive approach to innovation, research and collaborative working in the NHS and across industry and hope that this work continues.

We would like to acknowledge that the Trust is below the national trajectory for Clostridium Difficile following the appeals process agreed with the CCG. It is disappointing that for the fourth year, the Trust has not achieved the zero tolerance target for MRSA bacteraemia with 5 confirmed cases recorded in 2016/17. It is however, encouraging that the Trust has a proactive approach for reviewing each case and is analysing themes arising from these investigations, identifying key improvements. The Joint Health Care Associated Infection Improvement (HCAI) group will continue its positive contribution to this agenda and remain sighted on the issues.

It is encouraging that the Trust exceeded its 2016/17 target of staff participation in the Friends and Family Test with the results being utilised to improve communication within the Trust. It is hoped that this positive response rate and subsequent communication continues into 2017/18.

Increased communication and the improvement of patient experience is a theme and the CCGs wish to recognise and commend the work of the Trust in achieving the 2016/17 priority of focusing on patient experience and improving the timeliness of response to patient complaints. The development of the complaints handling policy and the implementation of software to monitor the progress of complaints within the Trust has had a significant effect on response times. The CCG is pleased to observe that the Trust demonstrates rigour in wishing to learn from patient experience with complaints being themed to identify and monitor trends and acting to prevent reoccurrence. It is encouraging that the obtaining of feedback from both patients/carers and employees about their experiences continues to be a priority for 2017/18.

The CCGs acknowledge the Trust's ongoing work in respect of Duty of Candour and await the data for 2016/17. The Trust continues to be a high performer in reporting incidents to the National Reporting & Learning System. The Trust reported a further 3 Never Events in 2016/17; which is disappointing as these are serious, largely preventable patient safety incidents that should not occur if providers have appropriate preventative measures in place. However, we are satisfied to see that following the Trust's root cause analysis investigations, there is no theme to the incidents and prompt identification of learning has taken place and a review of the Trust's policies and training took place to prevent their recurrence. The CCG would like to acknowledge the work done to date by the Trust in reducing the backlog of outstanding Serious Incident Root Cause Analysis reports and this will continue to be monitored by the CCG Serious Incident Panel and QRG.

The CCGs welcome the Trust's specific quality priorities for 2017/18 and consider that these are appropriate areas to target for continued improvements, which align to the CCGs commissioning priorities. We recognise the value of all of the priorities identified and appreciate the continuation of targets from 2016/17 some of which we acknowledge are recently implemented such as the revised process for reporting and investigation of hospital associated VTE events and some only partially met. We look forward to sustained improvements in sepsis management and implementation of the action plans to improve documentation in respect of Do Not Attempt Cardio Pulmonary Resuscitation orders and improvements in the patient fluid management and documentation. We are pleased to see that for each priority, a dedicated group will have responsibility for driving forward the changes.

In the coming year, the CCGs will be working with the South Tyneside and Sunderland Healthcare Group to implement transformation whilst ensuring the goal of ensuring that quality and safety of care remain at the heart of the partnership.

Much of the information contained within this Quality Report is routinely used as part of the quality monitoring process as described above. As required by the NHS Quality Reports regulations, the CCGs have taken reasonable steps to check the accuracy of this information and can confirm that it is believed to be correct. To conclude, the CCGs remain committed to working closely with City Hospitals Sunderland NHS Foundation Trust, in an open and transparent way, to ensure that the care provided for patients and carers is maintained at the highest possible quality standard in the most cost effective way.

Date: 16 May 2017

Statement from Sunderland Scrutiny Committee

Sunderland City Council's Overview and Scrutiny members are pleased for the opportunity to comment on this year's Quality Report. The report provides a detailed account of the quality of services and the key priorities for the year ahead. Scrutiny Members have a constructive relationship with City Hospitals Sunderland NHS Foundation Trust while at the same time providing a critical friend challenge, voicing the concerns of the public and acknowledging good practice and improvements in service delivery.

In looking at key priorities, the Health and Wellbeing Scrutiny Committee acknowledges the key aspects of patient safety, clinical effectiveness and the patient experience that the Trust is focusing on. In particular the Committee welcomes the level of work that has, and continues to be taken, around the in-patient management and care of patients with dementia, including the creation of a dementia-friendly environment.

In a period of prolonged austerity, where many public bodies are looking to new models and ways of working, the Scrutiny Committee is pleased to see the recognition for innovation in the Quality Report as well as the active promotion and encouragement of new ideas across the Trust.

The Scrutiny Committee is also satisfied that the Trust is continuing to achieve national operational and quality standards across a number of key measures. The Committee recognises the work being undertaken to improve those indicators which are below the standard set for 2016/17, and would welcome further performance information in the coming year to provide assurances around these indicators.

The formation of the South Tyneside and Sunderland Healthcare Group and the development of the Pathway to Excellence programme led to the creation of a Joint Health Scrutiny Committee between Sunderland and South Tyneside. The Joint Scrutiny Committee will work with both Trusts through this ambitious programme of reconfiguring services. The Path to Excellence is preparing for the first phase of consultation and the Joint Health Scrutiny Committee will be consulted formally on these specific service options, along with a wide range of stakeholders and the service users. . The Joint Scrutiny Committee will endeavour to act as the voice of local people throughout this programme, and work with the Trusts to ensure the best outcomes for local people.

The City Hospitals Sunderland NHS Foundation Trust and the local scrutiny function have a healthy relationship which has allowed for a robust collaboration over a wide range of health issues and local scrutiny members hope that this relationship will continue and are therefore happy endorse the Quality Report for 2016/17.

Date: 12 May 2017

Annex 2: 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.

NHS Improvement 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 2016/17 and supporting guidance;

- 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 2016 to March 2017;
    - papers relating to quality reported to the board over the period April 2016 to March 2017;
    - feedback from commissioners dated 16 May 2017;
    - feedback from governors dated 21 March 2017;
    - feedback from Overview and Scrutiny Committee dated 12 May 2017;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26 April 2017;
    - the 2015 national patient survey dated 8 June 2016;
    - the 2016 national staff survey dated 7 March 2017;
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 17 May 2017; and
    - CQC inspection report dated 20 January 2015.

- 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 NHS Improvement's annual reporting manual and supporting 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 2016/17. The Trust welcomes any comments you have about the current Quality Report but also asks you to help shape next year's 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.**