City Hospitals Sunderland
NHS Foundation Trust

Quality Report 2017/18

Contents

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 2018. 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

The Quality Report is one of the key ways the Trust demonstrates to the public and its stakeholders its services are safe, effective, caring and responsive. It provides an open and honest overview of the last year, including our many successes but also the challenges we have faced.

Trusts up and down the country have once again experienced unprecedented demands for their services, including ourselves. These have not just been concentrated in the high profile 'front of house' emergency care areas but across the whole spectrum of clinical services. At the same time we continue to be challenged to deliver these as safely and as cost-effectively as possible and in ways patients and their families feel is given with professionalism and compassion. All of this takes place with one eye on creating the future and working transformatively with our partners and stakeholders.

We have heard and seen in the news those hospitals that have struggled to cope with these pressures and competing priorities. I am pleased to report that for most of the time, City Hospitals Sunderland has stood strong throughout and risen to the many performance and quality challenges. In fact, we can show we have often exceeded them. That is testimony to the leadership, systems and governance arrangements we have in place, and of course to the individual and collective efforts of our staff who frequently 'go that extra mile'. This was again evident during the recent prolonged period of severe winter weather, where tremendous pressure was placed on our urgent and emergency care services with only minimal disruption to some non-urgent planned clinics and theatre lists. We should all be proud of this.

I mentioned last year the excellent progress made with our joint health alliance with South Tyneside NHSFT. This has continued at pace throughout 2017/18 and has culminated in the recent public announcement of the outcomes from the first stage clinical service reviews. Work is now underway on the final phase (phase two) and once again we will offer a genuine opportunity for the public, stakeholders and staff to express their views and opinions on changes. 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 year and, as previously mentioned, I believe we have achieved a great deal across the Trust. The Quality Report will summarise some of the more notable successes, acknowledging that many other examples exist throughout the Trust.

Another year has seen us achieve the vast majority of our Commissioning for Quality and Innovation (CQUIN) targets. This is an excellent achievement given the challenge of the national targets set, particularly around sepsis. Whilst we didn't always achieve our sepsis assessment and treatment targets, I know that good progress was made and a tremendous amount of work continues in this area. Further details about what we have done this year are provided in the appropriate section in the report.

We are starting to see the benefits from improving some of our key patient priorities such as reducing hospital acquired pressure ulcers and preventing patients falling. This is encouraging and our joint working, and sharing of knowledge and expertise with South Tyneside NHSFT will only consolidate this position. These important priorities are part of our new five-year strategy for quality, which sets out our 'road map' for patient safety and quality improvement. It describes the kind of organisation we aspire to be in terms of providing care which is safe, effective and given in a compassionate way. Next year, we will be able to report on its implementation and impact for the first 12 months.

We continue to participate in relevant national clinical audits and registries ensuring patients receive care that meets national standards. For most of the time, the outcomes show 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. Examples of the many audits we have participated in are included in the report.

We continue to closely monitor and review our mortality. The national 'Learning from Deaths' programme has provided the background for strengthening our Mortality Review Panel process. We have published a new policy on how we review and learn from deaths. In addition, we now publish information on deaths and the outcome of reviews at our board meetings in public. Our mortality data continues to show that we are about the same as most other similar organisations, although with one particular measure (Hospital Standardised Mortality Ratio), we have a higher rate than we would like but we are comfortable in acknowledging that this is due, for the most part, to the nuances of our admission and recording systems rather than the corollary of poor clinical care. We are also pleased to receive notification from the Care Quality Commission that our mortality outlier alerts are now formally closed.

Last year's report highlighted that City Hospitals was selected to be part of the new national Global Digital Exemplar (GDE) programme. This is a real accolade for the Trust and will help clinical staff to develop and transform the delivery of clinical services. Patients should also see and feel the difference as well. We continue to make significant progress with GDE and not only are we leading the field digitally but also playing a key role in supporting other sites as well. This includes South Tyneside Hospital as our 'fast follower' partner.

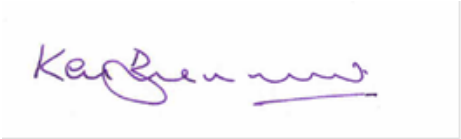
The results of our many patient satisfaction surveys show that we are meeting patient and public expectations most of the time. We have strengthened the ways in which we reflect and act on the results so that we don't lose the opportunities to improve our services. We received positive feedback from patients who used our Emergency Department, from children and their parents who had an inpatient stay and from mums-to-be who had their babies at City Hospitals. In fact, City Hospitals was the best performing Trust across the whole of the North East and North Cumbria when it comes to the care and attention women received in hospital after the birth of their babies.

Our staff also provided positive comments when completing the annual NHS Staff Survey. The Trust scored above the national average in many areas including the number of staff recommending the Trust as a place to work or receive treatment. We will be looking in detail at the results to understand where we can improve staff engagement and experience even further.

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.

As 2017/18 comes to a close, we look forward to welcoming the Care Quality Commission who will be undertaking their routine inspection of our services in the Spring 2018. We will also explore what further benefits a potential merger between ourselves and South Tyneside might bring for our patients and staff. This thinking, which is still very much at an early stage, will involve extensive staff and stakeholder engagement at an appropriate time.

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 2018

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

The Trust identified a number of key quality priorities for improvement in 2017/18. This section of the Quality Report shows how the Trust has performed against each of these priorities (shaded areas). In addition, there are a number of indicators of improvement that we have selected and these are described in more detail in Part 3.

		Improvement area	Objective	Rating
Patient Safety	Priority	Reduce the number of hospital developed pressure ulcers	Reduce avoidable category 2-4 hospital developed pressure ulcers by 25% in 2017/18 (part of a 3-year improvement plan)	
Clinical Effectiveness	Priority	Implement the recommendations from the national 'Learning from Deaths' programme	a) Develop a Trust-wide 'Learning from Deaths' policy b) Implement a new quarterly mortality dashboard for review at public Board meetings c) Strengthen the Trust Mortality Review Panel process d) Summary of learning from reviews of death in the Quality Report 2017/18	
Patient Experience	Priority	Improve the in-hospital management of patients with dementia	Implement the priorities from the national audit of dementia care in general hospitals	
Staff Experience	Priority	Increase the number of staff participating in the staff FFT	Increase the number of staff participating in the staff Friend and Family Test	

Priority achieved

Priority partially / mostly achieved or significant improvement achieved

Priority not achieved

2.1 Review of Priorities for Improvement 2017/18

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 2017/18; this is followed by a detailed account of our progress and achievements.

Patient Safety

We aim to be recognised as one of the safest healthcare organisations in the country. We want to treat and care for patients in a safe environment and promote 'harm-free' care.

Reduce the number of hospital developed pressure ulcers (HDPU)

Lead Contact: Debbie Cheetham – Head of Patient Safety & Experience

Target: Reduce avoidable category 2-4 HAPU by 25% in 2017/18 (part of a 3 year improvement plan)

Pressure ulcers (PUs) represent a major burden to the patient and to the NHS; they can have a life threatening and devastating impact on patients and their families. PUs are associated with an increased risk of secondary infection and are a major cause of morbidity, especially in older people. According to the literature, 95% of PUs are avoidable.

Over previous years the Trust has consistently appeared to be an outlier for Hospital Developed Pressure Ulcers (HDPUs), with a higher incidence than that reported by other Trusts. In order to address this, the Trust agreed a 3 year Pressure Ulcer Improvement Plan in June 2016 to outline strategies to reduce the incidence of avoidable HDPUs over

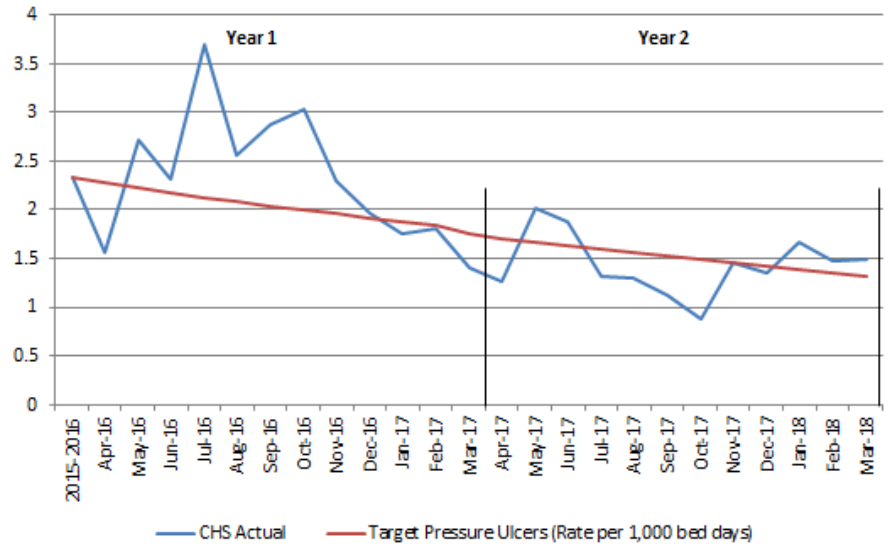
2016-2019. The improvement goal for City Hospitals was a 25% per annum reduction in avoidable category 2-4 HDPUs over the next 3 consecutive years (2016-2019). Using the metric of 'rate per 1,000 occupied bed days', this will amount to a gradual reduction from the baseline 2.33 (Trust 2015-2016 average) to 0.98 by 2019. The Trust's Ward Dashboard (WD) data indicating incidence and rate of avoidable category 2-4 HDPUs is utilised to map improvement.

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 evidence-based harm free care, by making real improvements in tissue viability using a holistic approach in relation to the prevention and management of pressure ulcers and complex wounds.

Summary of performance 2017/18

A detailed breakdown of the categories of HAPUs for 2017/18 from the Ward Dashboard data is shown below:

HAPUs	April 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Category 2	19	36	30	22	22	18	15	24	24	32	25	28
Category 3	1	0	1	0	0	0	0	0	0	0	0	0
Category 4	1	0	0	0	0	0	0	0	0	0	0	0
Total	21	36	31	22	22	18	15	24	24	32	25	28
Rate per 1,000 bed days	1.27	2.01	1.87	1.32	1.29	1.12	0.87	1.45	1.35	1.67	1.48	1.50
Target	1.71	1.67	1.64	1.60	1.57	1.53	1.50	1.46	1.43	1.39	1.35	1.31
	Q1 average = 1.67			Q2 average = 1.57			Q3 average = 1.46			Q4 average = 1.55		



HDPUs – actual performance against improvement trajectory (ward dashboard data)

The data demonstrates a downward trend in the incidence & rate of HDPUs over the previous 2 years. There was a notable increase in Q4 2017/18 which may be associated with "winter pressures", increased patient acuities and staffing pressures across the Trust, however, the same pattern was not evident in 2016/17. At the end of the second year of the improvement plan, Trust performance is at **1.50** HDPUs per 1,000 bed days which is above the improvement trajectory of **1.31** HDPUs per 1,000 bed days. However, the average rate over 2017/18 is **1.43** compared to **2.33** over 2016/17, which is a significant reduction. So whilst the end of year position is above the target improvement trajectory, the average performance over the year has significantly improved, demonstrating a reduction of **38.6%.**

Plans for 2018/2019

The Trust's TVSG will continue to lead on the improvement strategies outlined in the Pressure Ulcer Improvement Plan and monitor performance against this in order to achieve a further 25% in avoidable HDPUs over 2018/19 (the final year of the 3 year plan).

Clinical Effectiveness

Clinical effectiveness is aimed at making the care we give or the service we deliver more explicitly evidence based, with the goal of achieving excellent outcomes. It is about doing the right thing, at the right time, for the right patient and when all this happens together we can be confident that we have provided quality.

Implement the recommendations from the national 'Learning from Deaths' programme

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) Develop a Trust-wide 'Learning from Deaths' policy
b) Implement a new quarterly mortality dashboard for review at Board meetings in public
c) Strengthen the Trust Mortality Review Panel process
d) Summary of learning from reviews of death in the Quality Report 2017/18

For some people who come into hospital death is an inevitable outcome despite advances in medical treatment and receiving high quality care. However, there are occasions when care falls short of the standards expected and mistakes happen which can compromise patient recovery and even contribute to death. Where these events occur it is important that cognisance is taken of what happened, what needs to change and how we can ensure they don't happen again.

In December 2016 the CQC published its report 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'. Commissioned by the Secretary of State for Health in response to the very low number of investigations and reviews of deaths at Southern Health NHS Foundation Trust, the report found that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

In response, the National Quality Board (NQB) published guidance on a new learning from deaths framework https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf. One of the key requirements for Trusts was to publish a policy on how it responds to, and learns from, deaths of patients who die under its care. In addition, it mandated Trusts to publish information on deaths and reviews to be shared at Board meetings in public. We have responded to these requirements and made adjustments to our existing mortality review arrangements in the Trust. It is worth highlighting that we are part of a long standing Regional Mortality Network and together with our peers have worked together on improving our mortality review processes in advance of these national directives. This collaboration remains as relevant and supportive today as we look to introduce the Medical Examiner role into the NHS in 2019.

a) Develop a Trust-wide 'Learning from Deaths' policy

National guidance asked for all Trusts to have a policy in place setting out how they would respond to the deaths of patients who die under their care. In developing the policy for City Hospitals, the document included:

- the Trust's mortality review process, including the method used, how the scope of deaths for potential review is determined and how deaths are selected for review;
- how the Trust responds to the death of someone with a learning disability or severe mental health needs, of an infant or child, or a stillbirth or maternal death
- how the Trust decides which deaths – whether reviewed or not – require an investigation under the Serious Incident framework; and
- how the Trust engages with bereaved families and carers, including how they are supported by the Trust and involved in investigations where relevant.

The 'Mortality Review and Learning from Deaths' Policy was presented to the Board meeting in public in Sept 2017 and is available on the Trust's website at https://chsft.nhs.uk/application/files/3715/0771/8651/MD25.MRLD.V1.1_-_Mortality_Review__Learning_From_Death_Policy_-_Sep2017doc.pdf

b) Implement a new quarterly mortality dashboard for review at public Board meetings

Boards need to be assured that deaths are reviewed and changes are made in response to learning to improve patient care. Therefore Trusts are required to collect and publish quarterly reports with specified information on deaths and evidence of learning and action. The first Learning from Deaths Dashboard was published in November 2017 with the second in March 2018. We are working with our Communications Team to develop simple, textual infographics to accompany these reports to help the public better understand these complex data sets.

c) Strengthen the Trust Mortality Review Panel process

We have a well-established process in place for reviewing patient deaths and have worked closely with other Trusts in the North East to develop this approach. We use an adaptation of PRISM methodology (Hogan and colleagues) for undertaking mortality reviews. This clinician-led approach helps to identify 'problems in care' and informs judgements on avoidability of death. The method also allows clinicians to provide an overall quality of care rating on those deaths where care during the last admission was graded as excellent or good.

During 2017/18, we have made changes to create an enhanced two-stage mortality process that includes;

- a stage 1 screening review against nationally set criteria in order to identify a sub-set of patients for a more in-depth stage 2 independent review;
- the stage 2 review process now includes a G.P. to provide the primary care understanding of clinical decisions made. In all these cases none of the reviewers will have been directly involved in the clinical care of the deceased;
- a specific review of end of life care, which is carried out separate to or in addition to a stage 2 mortality review. These specific reviews are based on the 5 core elements of care from the national implementation of "Care of the Dying Patient" documentation. The outcomes of these reviews are used to target staff awareness and training sessions in care of the dying.

During 2018/19, we will work with colleagues within the Regional Mortality Network to prepare for the introduction of the Medical Examiner role from April 2019. Medical Examiners will be appropriately trained senior doctors who will verify clinical information on death certificates, ensuring that these are completed accurately and include appropriate referral to the Coroner's Officer, where relevant.

d) Summary of learning from reviews of death in the Quality Report 2017/18

Following an update on how Trusts produce their Quality Report, there was an additional requirement to publish information related to learning from deaths, including the number of patient deaths subject to case record review and whether any of these were more likely than not to have been due to problems in care. In addition, there is a narrative requirement to state what has been learnt from our mortality review process. The completed sections below meet the new requirements in full:

	Q1	Q2	Q3	Q4
During 2017/18, 1,534 of City Hospitals Sunderland patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:	357	310	381	486
By March 2018, 441 case record reviews and 0 investigations* have been carried out in relation to 1,534 of the deaths. In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: *investigations – deaths reported and investigated as a 'Serious Incident'	130	111	80	120
≤ 5, representing 0.2%, of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:	0.8%	0%	0%	0%

These numbers have been estimated using an adaptation of PRISM methodology (Hogan and colleagues) for undertaking mortality reviews. This clinician-led approach helps to identify 'problems in care' and informs judgements on avoidability of death. The method also allows clinicians to provide an overall quality of care rating and our Trust Mortality Dashboard presented at Board meetings in public captures those deaths whose care during the last admission was graded as excellent or good.

What we have learnt from case record reviews and investigations conducted in relation to the deaths.

Our mortality review process found ≤5 deaths that were more likely than not due to problems in care during the period. As an integral part of the Trust's mortality review process, individual minor issues regarding compliance with good standards of care were brought to the attention of the relevant departments in cases where care was deemed sub-optimal in the opinion of the reviewer.

An overview of actions taken

Our mortality review process is mature, having been in place for nearly four years. Therefore, unlike Trusts in the early implementation phase of a Structured Case Record Mortality Review process, simple impact measures have previously been identified and rectified by this Trust some years ago. Some examples of these include, improving the accuracy of death certification, resolving documentation issues through electronic systems such as discharge summaries, and improvements to the timeliness of specialty-led mortality reviews. We have also tried to improve the accuracy of Do Not Attempt Cardiopulmonary Resuscitation status and the process for notification of deaths to the coroner.

As we have a well-established and embedded process where action had already been taken on the simple impact measures, our learning focus is based on long-term multi-organisational issues. For example, we have identified potential for reviewing cases on a cross-organisational basis where a patient may have benefited from a formal Emergency Healthcare Plan (EHCP) prior to the admission leading to death.

In addition, given approximately half of deaths in hospital are expected, we now perform separate structured reviews of the quality of End Of Life Care in patients who are expected to die following admission. From these reviews, we have noted the difficulties health professionals experience when discussing resuscitation measures for the first time following an acute deterioration, despite clear indications that such discussions ought to have taken place during the weeks or months prior to the acute hospital admission. The Trust is liaising with community services to explore how these necessary discussions and decisions are conducted and recorded in a more timely and proactive way.

An assessment of the impact of these actions

We have employed an external reviewer to join the Mortality Review Panel. The Mortality Review Panel identifies cases for cross organisational review of patients who might have benefited from an EHCP in the community. The Trust provides monthly reports to wards that have provided end of life care to support areas of improvement and to acknowledge excellence.

0 case record reviews and 0 investigations completed after 31.03.2017 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using an adaptation of PRISM methodology (Hogan and colleagues) for undertaking mortality reviews.

0 representing 0% of the patient deaths during April 16 – March 17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Patient Experience

Ensure we give compassionate care and people have a positive hospital experience.

Improve the in-hospital management of patients with dementia

Lead Contact(s): Louise Burn – Deputy Director of Nursing & Quality (Corporate Lead)
Dr Lesley Young – Consultant and Clinical Lead for Dementia

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

At least one in four people accessing acute hospital services are likely to have dementia and the number of people with dementia is expected to double over the next 30 years. City Hospitals Sunderland has taken part in both main rounds of the National Audit of Dementia (NAD), in 2010 and 2012. The NAD measures the performance of general hospitals against criteria relating to organisational processes, care delivery and carer experience which are known to impact upon people with dementia while in hospital. The 3rd round was completed in September 2016 with results published in 2017 and included: a survey of carer experience of quality of care; a case note audit of people with dementia, an organisational checklist and a staff questionnaire examining support available to staff and the effectiveness of training and learning opportunities.

City Hospitals is committed to improving the in-hospital management of patients with dementia, and the national audit results has informed a multidisciplinary action plan which is monitored by the Dementia Steering Group. The areas for improvement for the quality priority include:

- **Identification and assessment of patients with dementia - ensure that cognitive screening takes place of all patients aged 65 and over (in line with NICE Guidelines);**
- **Information and communication - improve carer involvement with dementia patients; and**
- **Training - monitor the number of staff who receive dementia awareness training.**

Identification and assessment of patients with dementia - ensure that cognitive screening takes place of all patients aged 65 and over (in line with NICE Guidelines)

In 2012, the Department of Health required all hospitals to assess people aged 75 years and over, admitted acutely to hospital, for the possibility of dementia. The Trust achieved this target throughout 2015/16. This assessment was expanded in 2016/17 to all patients aged 65 and over, to ensure compliance with NICE guidelines 103. Assessing all patients aged 65 and over for the possibility of dementia has required significant education of staff, changes to electronic documentation and since 2016/17, ward level performance against the target has been included on ward dashboards to drive improvements at ward level.

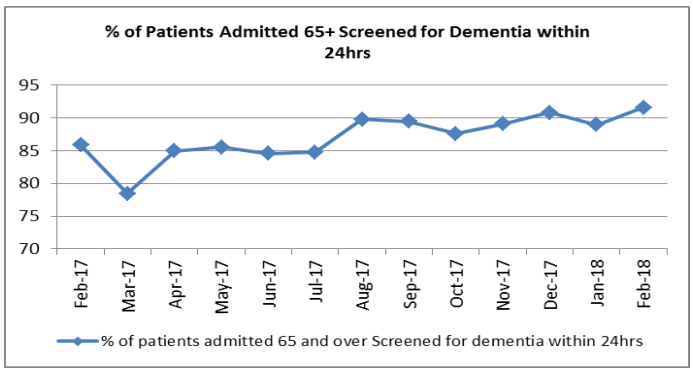


Table 1: % of patients screened for dementia

Table 1 demonstrates month on month improvements in the number of patients, aged 65 years and over who have been admitted, who were screened for dementia within 24 hours.

Information and Communication - 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 who 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. Results from the latest round of the National Audit of Dementia identifies that from a carer's perspective there is still improvement required to support carers in carrying out their caring role.

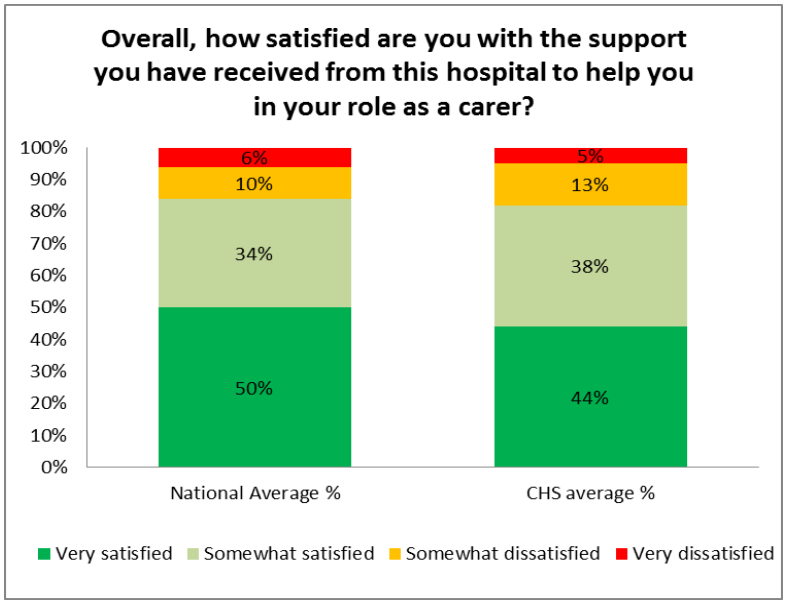
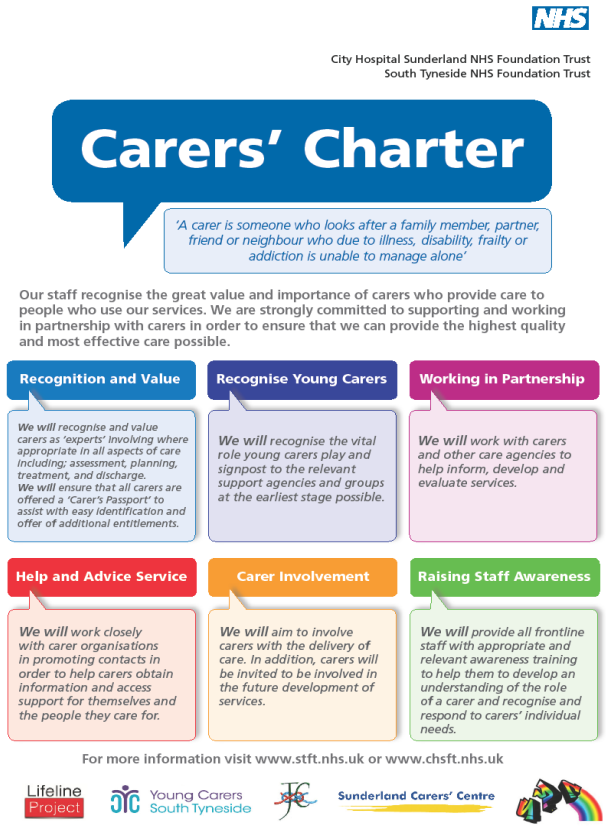


Table 2: Graph to show % of carers satisfied with the support received

The Carers' Charter

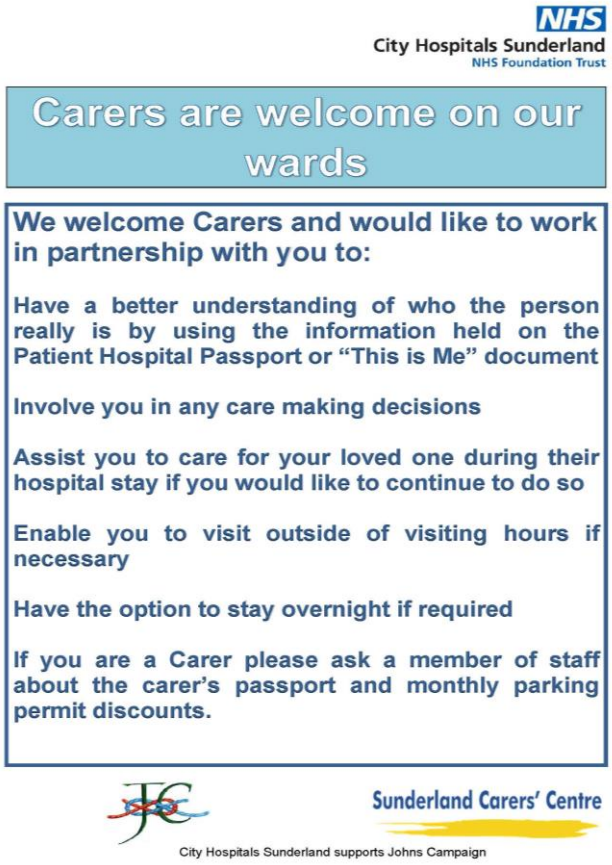


The Carers' Charter was updated in 2017 to reflect the alliance with South Tyneside NHS Foundation Trust and is displayed in all wards and departments as part of our ongoing initiatives to raise awareness and improve the experience of carers. It has also been reprinted to a larger A3 format to increase 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 was one of the first Trusts nationally to pledge support to deliver this campaign, and has actively promoted this during 2017/18, 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.

Training - Monitor the number of staff who receive dementia awareness training

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 induction, has been incorporated into a number of existing 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. NAD audit results identify that 39% of staff feel better prepared to provide care and support to people with dementia.

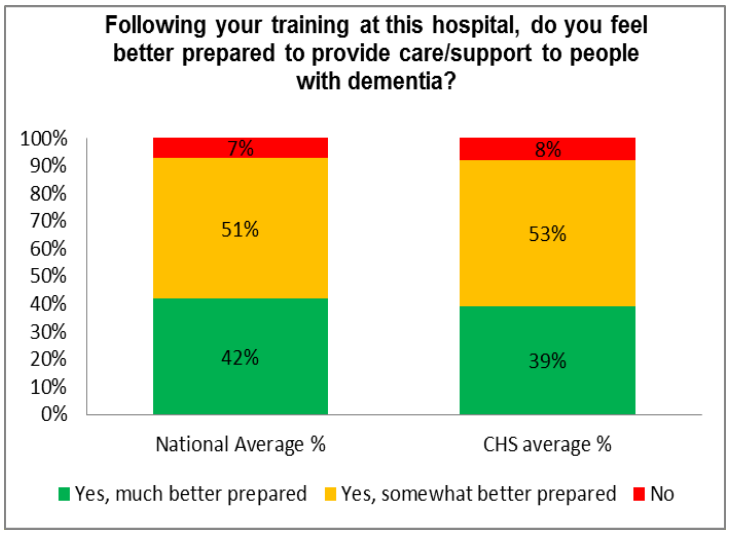


Table 3: Graph to show % of staff who feel better prepared to provide care /support to people with Dementia

Throughout the winter period the DDOT team has been called on to provide support to ward teams. This has impacted on the ability to deliver planned training sessions, as well as impacting on the clinical workload of the team.

What we will do in 2018/19

Our plans and development work for 2018/19 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 staff to get to know the patient on a personal level. Whilst this documentation is already available its use is not consistent in the Trust, and this will be reinforced throughout 2018/19;
- 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 slips, trips and falls. This can be extremely challenging in prioritising patient care in relation to those patients requiring 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 (basically a set of step-by-step instructions) is in the process of being developed to assist staff in delivering the least distressing and the most compassionate and safe level of care to patients.

Staff Experience

Increase the number of staff participating in the staff FFT

The Staff FFT provides an important opportunity for staff to feed back their views on working in City Hospitals at least once a year. This feedback will help to make changes to the working environment for staff wherever they may work in the organisation. We want to increase the number of staff who engage in the survey and make a commitment that we listen and act on their views.

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?

Trust level results are published each quarter by NHS England and made available on the NHS choices website. Data for 2017/18 for the two mandated questions is highlighted below. Note for the Quarter 4 survey this was only sent to midwives/qualified nurses across the Trust so it is not possible to compare our results to any national averages. This decision was taken by the trust Corporate Management Team.

	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*)	71% (409)	64%	70% (397)	63%	Annual staff survey	Annual staff survey	74% (106)	Not applicable
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*)	85% (409)	81%	83% (397)	80%			88% (126)	Not applicable

* No survey is undertaken in Quarter 3 as it coincides with the annual NHS Staff Survey
Source – NHS England (https://www.england.nhs.uk/fft/staff-fft/)

Whilst the number of staff completing a survey has fallen compared to last year, it is pleasing to see an improvement in the outcome scores, particularly in terms of staff recommending the Trust as a place for their family and friends to receive care and treatment.

After listening to the views staff shared in the 2016 Staff Survey, work has begun to improve the working environment and culture across both City Hospitals Sunderland and South Tyneside NHS Foundation Trusts. Whilst we have made some progress in the past 12 months, we know there is still much to do. Over the summer we held a number of staff focus groups to 'drill down' beneath the survey results and find out what issues colleagues felt were having the most impact on their working lives. The Trust has produced a booklet (below) for staff summarising some of the steps we have already taken, the feedback from the focus groups and, most importantly, what we still need to improve moving forward. Some examples of what we have done already are highlighted below:

- Implemented our 'Dignity at Work Policy' with 'Dignity at Work Advisors' in place to support colleagues who have concerns about bullying or harassment;
- Strengthened Team Brief sessions and held quarterly staff briefings / roadshows;
- Improved our social media presence on Twitter and Facebook to share good news and information;
- A new 'Leadership and Talent Management' strategy has been approved and an operational plan is being developed to improve leadership, development and training across both Trusts;
- Invested in apprenticeship opportunities across a number of areas, including administration, healthcare and leadership;
- Continued to hold our annual 'Reward and Recognition Awards' to ensure we have a formal way to recognise outstanding achievement and celebrate success;
- Implemented a fast track physiotherapy service, health MOTs and ergonomic assessments for staff;
- Provided an on-site Health and Fitness Centre for staff;
- Organised an annual Employee Benefits Day to give information on what staff benefits, discounts and support services are available.

Priorities for quality improvement 2018/19

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 2017/18, 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 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;
- patient, carer and public feedback on Trust services, including Friends and Family Test, national patient surveys and our patient experience surveys;
- learning from complaints, HAAS, 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 has also been guided by the development of our new Quality Strategy which provides an overview of our strategic framework and plan of action to improve quality of care at City Hospitals Sunderland and South Tyneside NHS Foundation Trusts over the next five years. Our vision is to be an outstanding provider of healthcare for everyone who comes into contact with our services, both in hospital and in the community. Our quality priorities will form an integral part of the implementation and success of the Quality Strategy in 2018/19 and in subsequent years.

	Patient safety	Measured by	Monitored by	Reporting to
1	**Reduce the number of hospital acquired pressure ulcers**	**Ward Dashboard data**	**Tissue Viability Steering Group**	**Clinical Governance Steering Group**
	Target: Reduce the incidence of category 2-4 pressure ulcers which have developed in our care by 25%			
	Reason why we chose this priority The Trust has targeted a 3-year programme of improvement to reduce the incidence of hospital acquired pressure ulcers, which we started in 2016/17. Our aim was to reduce category 2-4 pressure ulcers (the most damaging and disabling ulcers) by 25% each year for the duration of the plan. Over that time a number of initiatives have been implemented across wards and departments which have been co-ordinated and evaluated by the Tissue Viability Steering Group. We now have a joint approach to improving the prevention, assessment and management of pressure ulcers with colleagues at South Tyneside and together we participate in a Regional Pressure Ulcer Reduction Collaborative.			
2	**Reduce the incidence of patient falls that result in moderate or above harm**	**Incident reporting system**	**Falls Reduction Group**	**Clinical Governance Steering Group**
	Target: To be in the lower quartile of reporting trusts nationally with respect to harm caused by inpatient falls			
	Reason why we chose this indicator We know that some patients fall whilst they are in our care and a small number of these do suffer harm as a consequence. This tends to be the most common incident that is reported by NHS Trusts, and this is also something which is part of our incident reporting profile. We have already implemented many national and local initiatives to improve the assessment and management of those patients most vulnerable to slips, trips and falling. This focus and consolidation into practice needs to continue so we are confident we are managing the risk of falling as much as possible. For 2018/19 our target is to reduce the incidence of severe harm from patient falls, such that we are in the lower quartile of reporting Trusts nationally.			

3	**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**
	Target: 10% improvement on the previous year			
	Reason why we chose this indicator Although we have been able to report some improvements in our documentation and communication of DNACPR orders over the past few years, there is still further work required to be confident that we are getting it right all of the time. Therefore we intend to focus on this area as a Trust priority and our aim is to achieve a 10% improvement in DNACPR documentation based on delivery of an action plan.			
4	**Improve the recognition and management of deteriorating patients**	**a) Local systems of audit** **b) National Cardiac Arrest Audit**	**a) Matrons Group** **b) Resuscitation Group**	**Clinical Governance Steering Group**
	Target: a) 100% of patients to have accurate and timely recording of Early Warning Scores **b) 5% reduction in the number of preventable cardiac arrests**			
	Reason why we chose this indicator Hospital staff are increasingly confronted with the challenge of providing acute care to an ageing population with multiple co-morbidities, who undergo complex medical and surgical interventions. Due to the higher acuity of these patients, they are at risk of deterioration, which may lead to cardiac arrest and death. We now know that antecedent signs of cardiac arrest are present long before the event. If these signs are identified and managed appropriately, these deaths may be preventable. a) The Trust uses the national early warning score system (NEWS) to help identify patients whose health may suddenly become worse. Information from incidents and audits have shown that sometimes patient observations were not always recorded in a timely manner and early warning scores were not acted upon in time to prevent further deterioration. We want to make sure that all our patients have accurate and timely recording of early warning scores; b) Similarly, timely response and intervention by the clinical team can prevent cardiac arrest and improve recovery. To date we have made only modest improvements in reducing preventable cardiac arrests and we need to do much better.			
5	**Improve the standards of clinical documentation**	**Local assurance audits**	**Trust Nutritional Group**	**Clinical Governance Steering Group**
	Target: a) Achieve at least 90% compliance with nutritional screening on admission to hospital **b) Achieve at least 90% compliance with recording of fluid input and output**			
	Reason why we chose this indicator a) Evidence suggests we should identify those patients most at risk of malnutrition and put measures in place to improve nutritional status. The Malnutrition Universal Screening Tool (MUST) is one such screening tool that is proven to be effective in identifying adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. Patients should be screened by a registered nurse within 24 hours of admission to hospital; however, audits have shown this does not always happen. We want to make sure that we carry out our MUST assessments in a timely and effective way; b) Information from our audits also shows the standard of some of our fluid balance recordings could be improved. There is also evidence that trends which give cause for concern are not escalated appropriately. The Trust has recently introduced a new fluid monitoring chart to help improve recording for those vulnerable patients that need it most.			

6	**Improve medication management**	**Internal report and audit**	**Medicines Safety Group**	**Clinical Governance Steering Group**
	Target: a) Ensure medicines reconciliation is achieved for 95% of patients within 24 hours of admission to our hospitals **b) Reduce the incidence of missed doses of medicine by 50%.**			
	Reason why we chose this indicator Medication use has become increasingly complex in recent times and medication error is a major cause of preventable patient harm. This priority highlights two areas in which staff can make medication use safe: a) Medicines reconciliation is the process of ensuring that a hospital patient's medication list is as up-to-date as possible. It is usually undertaken by a pharmacist, and may include consulting several sources such as the patient, their relatives or carers, or their GP. Best practice guidance states that medicines reconciliation should be carried out within 24 hours of admission to hospital; b) When a medicine is prescribed there is usually the understanding that the patient will have the medicine administered according to the prescription schedule. Failure to do so can lead to, or has the potential to lead to, patient harm. Missed doses of high-risk drugs are potentially a bigger risk to patients and may result in increased morbidity and mortality. We want to put in place a series of measures to reduce occasions where medications are missed, for whatever reason.			

	Clinical Effectiveness	**Measured by**	**Monitored by**	**Reporting to**
1	**Implement the recommendations from the National Maternity Safety Strategy**	**Maternity Indicators and Action Plan**	**O&G Clinical Governance Group**	**Clinical Governance Steering Group**
	Target: implement the 10 criteria for safer maternity care (agreed by National Maternity Champions)			
	Reason why we chose this priority A new national Maternity Strategy was launched by the NHS in support of its ambition to halve the number of stillbirths, deaths and brain injuries by 2025. It is widely acknowledged that improvements need to be made in learning from mistakes to reduce the number of injuries and baby deaths in childbirth. The strategy is wide ranging and includes initiatives to provide better and safer maternity care, improve the quality of information reviews and investigations and enhance opportunities for learning. In addition, the strategy sets out incentives for those maternity units to implement best practice. The Trust already has a high performing maternity service that is safe and effective which is rated highly by women and their partners. We want to consolidate this position and become one of the safest maternity units in the country.			
2	**Improve the outcomes for patients with serious infection by ensuring timely identification and treatment of sepsis**	**NHS Digital**	**Sepsis Group**	**Clinical Governance Steering Group**
	Targets: Sepsis assessment - 90% of screened cases **Antibiotic Administration - 90% of patients with sepsis treated within 1 hour** **Antibiotic Review - Perform an empiric review for at least 90% of cases in the sample**			
	Reason why we chose this priority Evidence suggests that poor initial assessment and delays in treatment for sepsis can have a major negative impact on patient outcomes and can contribute to high mortality. Improvement in sepsis management forms part of the national CQUIN scheme with the requirement for hospitals to implement screening protocols 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 and that these drug regimes are properly reviewed. We have set up processes aligning to national standards in assessing patients for sepsis and, if clinically necessary, to initiate treatment in a timely way. Monitoring of this priority will be overseen by the Trust Sepsis Group.			

3	**Improve quality, efficiency and reduce variations in our services by implementing recommendations from the GIRFT programme**	**Specialty Specific Action Plans**	**Operational Management Group**	**Clinical Governance Steering Group**
	Target: Implement specialty-specific recommendations from GIRFT (according to agreed action plan)			
	Reason why we chose this priority Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. Fundamentally it is about improving quality and by doing so this leads to a reduction in costs. A national report highlighted that unwarranted variation affects patient outcomes, service costs and overall productivity. This does not mean that all Trusts should be the same as local needs will shape services and priorities, however the programme is designed to identify changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of any potentially unnecessary procedures. It is important to recognise that GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins GIRFT is being reviewed by people who understand and manage those services on a daily basis. The GIRFT methodology is being rolled out nationally and will include most clinical medical specialties. City Hospitals has already been part of the process and is committed to using the intelligence within GIRFT to raise quality and standards.			
4	**Learn and act on the results from reviews of patient deaths**	**Mortality Review Outcomes**	**Mortality Review Group**	**Clinical Governance Steering Group**
	Target: Review all deaths that meet national criteria for stage 2 independent review			
	Reason why we chose this priority Nationally it is recognised there are major limitations to hospital mortality statistics and how these can be interpreted. In response, the main method of assessing the safety and quality of care received by deceased patients is to undertake retrospective case note review. For some time, the Trust has undertaken systematic mortality reviews to better understand and learn from hospital deaths. Last year, we published the outcomes of this information in the form of 'Learning from Deaths Dashboard' which included evidence of learning and action as a result of any problems in care. We will continue to develop our processes and methods of sharing this important information with the public which will be overseen by the Trust Mortality Review Group.			
5	**Integrate the four priority standards for seven day working.**	**Action Plan Updates**	**Operational Management Group**	**Clinical Governance Steering Group**
	Target: Four priority standards to be implemented by 2020			
	Reason why we chose this priority The NHS has committed to providing a 7 day service by 2020. The expectation is that all in-patients admitted through emergency and urgent care routes have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout their stay in an acute hospital bed. The rationale for this ambition is to improve safety, quality and efficiency of care, ensuring senior decision makers are available to provide the same level of assessment, diagnosis, treatment and intervention on each day of the week. The expectation is that these senior staff will also be readily available to provide information to patients and relatives and to supervise junior staff. A number of standards have been set of which four are designated as priority standards as these are most closely linked to the improvement in safety and efficiency. It is these four standards that the NHS expects to be in place for all Acute Trusts by 2020.			

	Patient Experience	Measured by	Monitored by	Reporting to
1	**Learn from patient feedback**	National and local surveys, NHS Friends and Family Test, complaints, compliments and online sources (e.g. NHS Choices)	Patient, Carer and Public Experience Group	Patient, Carer and Public Experience Committee
2	**Ensure patients are involved as much as they want to be in decisions about their care and treatment by monitoring and audit**		Patient, Carer and Public Experience Group	Patient, Carer and Public Experience Committee
3	**Provide a safe, secure, clean and comfortable environment for our patients and their carers/families by monitoring hand hygiene compliance and infection rates**	Audit of compliance and annual PLACE inspection results	Patient, Carer and Public Experience Group	Patient, Carer and Public Experience Committee
4	**Ensure patients receive adequate information and support for safe discharge from hospital by monitoring and audit**	National patient surveys and local real time feedback	Patient, Carer and Public Experience Group	Patient, Carer and Public Experience Committee
5	**Ensure all patients, and specifically those with physical and mental disabilities, receive person-centred care based on their needs and preferences and that we work within the Mental Capacity Act (2005) and consult with others where appropriate. One of the key vulnerable groups will be patients with dementia**	Local Dementia Group Action Plan	Patient, Carer and Public Experience Group	Patient, Carer and Public Experience Committee

Reason why we chose these priorities

Whilst safe, high quality clinical care must always be guaranteed in the NHS, this isn't enough by itself. Patients want, and deserve to be treated with compassion, dignity and respect in a safe and caring environment, with staff putting the needs of patients first to ensure a consistent positive patient experience. Our aim is to improve the patient and carer/family experience, from their very first contact with us right through to their safe discharge from our care.

A range of feedback mechanisms will be used to help the Trust understand the patient experience whilst in hospital, particularly with regard to some of the key areas highlighted above. It will also provide a useful way to measure improvement following the actions we will take. Our progress, achievements and challenges for making improvements will be monitored by the Patient, Carer and Public Experience Group.

Part 2.2 Statements of assurance from the Board of Directors

Review of services

During 2017/18 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 2017/18 represents 100% of the total income generated from the provision of relevant health services by City Hospitals Sunderland for 2017/18.

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 the 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 an important and useful way to help improve standards of clinical care. The process involves evaluating patient care against expected standards and where necessary, making changes to improve outcomes for patients. A re-audit can then be used to confirm improvements have been effective. Clinical audits can look at care at a national level and compare practice with other hospitals or be more focused on what takes place in wards and department in local hospitals and 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 a mandatory requirement. 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 comparative picture of performance against peers. NCAPOP also encompasses the national confidential enquiries. These are now known as Clinical Outcome Review Programmes (for consistency and clarity these will continue to be called national confidential enquiries in this report).

During 2017/18, 44 national clinical audits and 9 national confidential enquiries covered relevant health services that City Hospitals Sunderland provides.

During that period City Hospitals Sunderland participated in 91% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that City Hospitals Sunderland participated in, and for which data collection was completed during 2017/18, 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 Enquiries 2017/18

National Clinical Audits 2017/18	Eligible	Participation	Comment
Older People			
Falls and fragility fractures audit programme including (Royal college of physicians)			
- National hip fracture database	✓	✓	415 cases (100%) January to December 2017
- Fracture liaison service database	✓	✓	1690 cases (99%)
- National inpatient falls audit	✓	✓	30 clinical cases submitted (100%) 1 Organisational proforma
Sentinel stroke national audit programme (Royal college of physicians)	✓	✓	778 cases (100%)
National audit of dementia (Royal College of Psychiatrists)	✓	✓	Round 4 to commence April 2018
National audit of breast cancer in older people (Royal College of Surgeons of England)	N/A	N/A	
Women and Children's Health			
Neonatal intensive and special care (NNAP Royal college of paediatrics and child health)	✓	✓	305 cases (100%)
Paediatric diabetes (Royal College of Paediatrics and Child Health)	✓	✓	194 children audited in 2017/18 based on 2016/17 patients.
Paediatric intensive care (PICANeT)	N/A	N/A	
National maternity and perinatal audit (Royal College of Obstetricians and Gynaecologists)	✓	✓	Continuous data collection
Acute Care			
Adult critical care (CMP Intensive care national audit research centre)	✓	✓	943 cases (100%)
National emergency laparotomy audit (National College of Anaesthetists)	✓	✓	182 cases (100%)
National joint registry (Healthcare Quality Improvement Partnership)	✓	✓	992 cases
Major trauma (Trauma audit and research network TARN)	✓	✓	311 cases (95.1%) January to December 2017
Nephrectomy (British Association of Urological Surgeons)	✓	✓	159 cases January to December 2017
Percutaneous nephrolithotomy (British Association of Urological Surgeons)	✓	✓	34 cases January to December 2017
Radical prostatectomy (British Association of Urological Surgeons)	✓	✓	84 cases January to December 2017
Cystectomy (British Association of Urological Surgeons)	✓	✓	39 cases January to December 2017
Urethroplasty (British Association of Urological Surgeons)	N/A	N/A	Currently not performed at SRH
Fractured neck of femur (Royal College of Emergency Medicine)	✓	✓	50 cases (50%)
Pain in children (Royal College of Emergency Medicine)	✓	✓	51 cases (100%)
Procedural sedation (Royal College of Emergency Medicine)	✓	✓	50 cases (100%)
National audit of seizures and epilepsies in children and young people	✓	✓	Audit currently being undertaken
National bariatric surgery registry (NBSR British Obesity and Metabolic Surgery Society)	✓	✓	383 cases
Cancer			
Bowel cancer (NBOCAP Royal College of Surgeons of England)	✓	✓	164 cases (not able to determine percentage; audit submission deadlines not reached yet)
Head and neck cancer (HANA Saving faces- The facial surgery research foundation)	✓	✓	309 cases (not able to determine percentage; audit submission deadlines not reached yet)
Lung cancer (NLCA Royal College of Physicians)	✓	✓	352 cases (not able to determine percentage; audit submission deadlines not reached yet)

National Clinical Audits 2017/18	Eligible	Participation	Comment
Oesophago-gastric cancer (NAOGC Royal College of Surgeons of England)	✓	✓	15 cases (not able to determine percentage; audit submission deadlines not reached yet)
Prostate cancer (Royal College of Surgeons of England)	✓	✓	478 cases (not able to determine percentage; audit submission deadlines not reached yet)
Long term conditions			
UK Parkinson's audit (Parkinson's UK)	✓	✓	44 cases – the minimum required by Parkinson's UK was 20
Inflammatory bowel disease – IBD registry	✓	X	Not able to participate due to resource issues
Endocrine and thyroid (British Association of Endocrine and Thyroid Surgeons)	✓	✓	107 cases
Learning disability mortality review programme (LeDeR University of Bristol)	✓	✓	14 patients were eligible for LeDeR review (aged 4 – 74). Of these notifications, 6 reviews are complete, 6 reviews are in progress and 2 multi agency reviews are pending.
National chronic obstructive pulmonary disease audit programme (Royal College of Physicians)	✓	✓	April 2017 – March 2018 – 635 (provisional). Organisational questionnaire also completed
National diabetes audit adults (NHS Digital)	✓	✓	2522 cases submitted July 2017 for the period January 2016 to March 2017
National ophthalmology audit (Royal College of Ophthalmologists)	✓	X	No data submitted to site - not IT compatible. Developing V6 solution as part of the GDE project.
Female stress urinary incontinence (British Association of Urological Surgeons)	✓	✓	22 cases January to December 2017
Heart			
Acute coronary syndrome or acute myocardial infarction (MINAP National Institute for Cardiovascular Outcomes Research)	✓	✓	448 cases (100%)
Adult cardiac surgery	N/A	N/A	
Cardiac rhythm management (National Institute for Cardiovascular Outcomes Research)	✓	✓	235 cases (100%) January to December 2017
Congenital heart disease (National Institute for Cardiovascular Outcomes Research)	N/A	N/A	
Coronary angioplasty/national audit of percutaneous coronary interventions (National Institute for Cardiovascular Outcomes Research)	✓	✓	761 cases (100%) January to December 2017
Heart failure (National Institute for Cardiovascular Outcomes Research)	✓	✓	236 cases (66%) April 2017 to February 2018
Cardiac arrest audit (Intensive Care National Audit and Research Centre)	✓	✓	123 cases (100%)
Vascular registry (Royal college of surgeons of England)	✓	✓	205 cases (100%)
Mental health			
Prescribing observatory for mental health (POMH-UK Royal College of Psychiatrists)	N/A	N/A	
National audit of psychosis	N/A	N/A	
Blood and transplant			
National comparative audit of blood transfusion programme (NHS Blood and Transplant)			
- Serious hazards of transfusion : UK national haemovigilance scheme	✓	✓	13 cases (100%)
- Red cell and platelet transfusion in adult haematology patients	✓	✓	42 cases (100%)
- Use of FFP and cryoprecipitate in neonates and children	✓	✓	Audit commences spring 2018.

National Clinical Audits 2017/18	Eligible	Participation	Comment
Other			
Elective surgery (National patient reported outcome measures programme NHS Digital)	✓	✓	2124 cases (71.1%) April 2016 to March 2017
Specialist rehabilitation for patients with complex needs following major trauma	N/A	N/A	
Neurosurgical audit programme	N/A	N/A	
National audit of anxiety and depression	N/A	N/A	
National audit of intermediate care (NHS benchmarking network)	N/A	N/A	

Source: Quality Accounts Resource 2010-2017 (Healthcare Quality Improvement Partnership)

National Confidential Enquiries (Clinical Outcome Review Programmes)

As has been stated earlier these are collectively known as Clinical Outcome Review Programmes. These enquiries or types of audit are designed to help assess the quality of healthcare by reviewing the care provided to patients for specific conditions. City Hospitals continues to take part in all relevant enquiries.

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

Enquiry title	Organisation	Acronym
Child death review database	National Perinatal Epidemiology Unit & University of Leicester	NPEU
Child health clinical outcome review programme • Chronic neurodisability • Adolescent mental health	National Confidential Enquiry into Patient Outcome and Death	NCEPOD
Learning disability mortality review programme	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

A detailed overview of our specific contribution to the medical and surgical programme known as the National Confidential Enquiry into Patient Outcome and Death is highlighted below.

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 2017/18 City Hospitals was eligible to enter data into 4 NCEPOD studies. The tables below provide a summary of our participation:

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 *
Admission Questionnaire	11	1	11	0	11	0
Lead Clinician Questionnaire	10	0	10	0	10	0

*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.

Young Person's Mental Health - identify remediable factors in the quality of care provided to young people treated for mental health disorders. Examine the interface between different care settings and examine the transition of care

Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Org. Q. requested *	Org. Q. returned*
Admission Questionnaire							
6	0	6	0	6	0	2	2

Cancer in Children, Teens and Young Adults - 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	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Org. Q. returned*
Intensive Care Unit (ICU) Cases							
0	0	0	0	0	0	1	1
Systemic anti-cancer therapy (SACT) Cases							
0	0	0	0	0	0	Not applicable	Not applicable

Acute Heart Failure – identify and explore avoidable and remediable factors in the process of care for patients admitted to hospital with acute heart failure

Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *
5	1	5	1	5	1

Perioperative Diabetes – identify and explore remediable factors in the process of care in the peri-operative management of surgical patients with diabetes across the whole patient pathway from referral for surgery (elective) or admission to hospital (emergency) to discharge from hospital

Cases included	Cases excluded	Clinical Q returned *	Excl. Clinical Q returned *	Case notes returned *	Excl. Case notes returned *	Sites participating	Org. Q. returned*
5	1	Surgical Qs. 4	1	2	1	2	0
		Anaesth. Qs 4	0				

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

National clinical audits

The reports of 9 national clinical audits were reviewed by the provider in 2017/18 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 Audit of Dementia (Round 3 2016/17)	• This is a comprehensive audit involving a review of organisational structure, patient care and a carers' and staff survey; • The Trust scored highly in areas such as; initial screening for delirium/ dementia (better than twice the national average), clinical assessment, use of a standard mental test score (to assess elderly patients for dementia), and multidisciplinary assessment of mobility, continence and nutrition; • From a staff perspective, support was available to them from specialist dementia services (within the hospital); • The audit shows we need to improve the recording of information about the patients' personal routines and those factors that cause distress and promote calm; • Carers felt they wanted to be involved more in decisions and to be kept better informed. The systems for coordinating discharge also needed to be improved; • The Trust Dementia Strategy Group will draw up a revised action plan using information from the audit.

Myocardial Ischaemia National Audit Project (*Heart Attacks*)	• The audit looks at heart attack and its treatment from 1 April 2015 – 31 March 2016. It captures the patient journey, from a call to the emergency services or self-presentation at an Emergency Department, through diagnosis and treatment at hospital, to the prescription of preventive medications on discharge; • National standards published by NICE were being met or exceeded in areas such as access to angiography, management by a cardiologist, being cared for on a specialist ward, prescription of secondary prevention medication and length of stay; • Performance standards around Primary Percutaneous Coronary Intervention (procedure used to treat the narrowed coronary arteries of the heart) are less than the national mean. The complex factors affecting performance were discussed at Clinical Governance Steering Group and with Commissioner colleagues.
National Joint Registry	• This provides a contemporary record of joint replacement surgery for hips, knees, elbows, shoulders and ankles in England and Wales; • Clinical outcomes data shows that for hip and knee replacement surgery over a 10 year period, the revision rate (surgery performed to replace or compensate for a failed implant) is consistently better than the national average. Revision rate is one of the most important outcome measures of joint replacement surgery; • All joint surgeons' standardised revision ratios are well within the funnel plot curves; this is the same for resurfacing procedures; • Mortality is at the national average, in spite of the demographic profile which shows that some patients are acutely unwell with multiple health problems.
National Heart Failure Audit	• The audit monitors the care and treatment of patients with acute heart failure (the heart fails as an effective pump); • Most performance indicators are in the top quartile, for example, the majority of patients receive an echocardiograph (99.7% compared with a national figure of 90.1%); • We have a very different model of care in Sunderland for managing patients with heart failure, which the national audit doesn't recognise i.e. input from a geriatrician with special interest in cardiology who works very closely with cardiology colleagues; • Input from a 'specialist', i.e., cardiology consultant, medical consultant, specialist pharmacist was 94.5% which is much higher than the national average of 79%; • Use of modifying drugs prescribing is well above the national average; • Discharge planning is comparable to the national average, 84.8% compared to 87.3%. Heart Failure nurse follow-up is much better than average; • The Inpatient Heart Failure team is reviewing how they wish to develop the future state of the service as they work closer with South Tyneside.
National Hip Fracture Database 2017	• The database is a clinically led audit of hip fracture care and secondary prevention; • The current service model at City Hospitals for managing hip fractures benefits from having; orthogeriatric input as part of an integrated service (full time cover on wards including weekend), named consultant anaesthetics cover for each trauma list and a weekend trauma rota, true multidisciplinary clinical working, 7-day physiotherapy service with trauma commitment and a Fracture Liaison Service; • Clinical performance against peers shows many outcomes in the top quartiles, including; timely admission to appropriate ward, pre-op medical assessment, completed nutritional and delirium risk assessments, length of stay (16 days compared with 21.6 average NHFD), and follow up; • City Hospitals is also in the top quartile (81.3%) for meeting the best practice tariff criteria (which is an evidence-based plan of care); • There are only a couple of areas where the Trust is outside the top quartile: hip fractures sustained as an inpatient and documentation of pressure ulcers. Changes have been made to the clinical pathway to address these issues.

Local clinical audit

The reports of 210 local clinical audits were reviewed by the provider in 2017/18 and City Hospitals Sunderland intends to take the following actions to improve the quality of healthcare provided.

Audit title	Good outcomes / Actions taken
Neonatal Unit - analysis of term admissions to neonatal care	• Term admission is considered a harmful outcome as it interrupts natural bonding between the mother and baby which can lead to mental health issues, trouble with breastfeeding and long-term morbidity. ATAIN (Avoiding term admissions in neonatal units) is a national quality improvement programme to prevent term admissions to neonatal unit; • The trends in term admissions to the Neonatal Unit show a decline in term admission numbers and are similar to previous audits; • Social admissions remain the same at 14% in spite of various measures in place and are expected to increase due to social deprivation in this area; • Term admissions due to respiratory causes has come down (46% vs 52% in previous years); • Term admissions due to infections and jaundice continue to be lower than national average.
Paediatrics - development of an electronic Paediatric Emergency Department Asthma Assessment Tool (PEDAAT) to identify high risk children	• 82.9% of applicable standards were recorded in the PEDAAT Group vs 51.9% when standard PED clinical documentation was used alone; • PEDAAT application resulted in receipt of a Personal Action Plan in 72.7% vs 30.8%; • PEDAAT was completed for only 13 of 548 (2.4%) PED attendances with wheeze/asthma due to lack of knowledge of tool existence, IT accessibility, practicality, and absence of guidance regarding follow up; • A revised, concise, user-friendly, click-box PEDAAT-2 was developed, automatically identifying and referring eligible children to a newly established Paediatric Respiratory Nurse-Led PED Asthma clinic; and • A re-audit is planned using this new tool.
Trauma & Orthopaedics - an audit of patient outcomes after total ankle replacement	• Audit was undertaken to review functional outcomes following ankle replacement, including complications and morbidity; • STAR ankle replacement is associated with significant improvements in pain and function (especially after 1 year once the pain and swelling settled); • Sunderland's function/pain outcomes are comparable to other publications; • Sunderland has reduced complication rates compared to published data; • Ankle replacement outcomes improve with surgeon experience; • Longer follow up is required for more accurate analysis.
Pharmacy - an audit into whether medications administered during admission to the paediatric wards are prescribed on the Trust's electronic prescribing software	• The audit captured data on 45 patients who were admitted to ward F64 (paediatric inpatient ward); • 117 different medications were administered in the paediatric emergency department and F64 collectively, of which 113 (96.6%) had a corresponding record on the electronic prescribing system; • Some other prescribing issues were identified during this audit related to drug dosing, the brand used and an inappropriate stop date for steroids; • In general, the audit showed that the majority of medications administered within the PED and F64 had an appropriate system entry, as per the guidance in the Medicines Management policy.
Pharmacy – is amitriptyline (*an antidepressant*) reviewed in elderly care patients admitted to City Hospitals with a fall?	• The number of patients identified as taking amitriptyline was lower than expected which may be due to a decrease in prescribing in the community; • There is scope for improving the identification of medications for review in a patient who is admitted with falls; at the time of the audit there was no specialist falls pharmacist in post but a post has since been created; • Future work includes the documentation of falls review on the hospital computer system, possibly with a dedicated document, and also communication of relevant information within the discharge letter.

Intensive Care - compliance with venous thromboembolism (VTE) prophylaxis in the Integrated Critical Care Unit at Sunderland Royal Hospital	• Critically ill patients are at an increased risk of venous thromboembolism (blood clots);adherence to VTE prophylaxis should be a priority for this clinical group; • Overall compliance with recommendations for drugs used to prevent VTE was high but lower than in the previous audit; • The audit highlighted the need for improvement with VTE prophylaxis, particularly in the first 24 hours admission to ICCU; • The specialty is to develop a checklist to improve compliance on admission.
Rheumatology - Rituximab use in rheumatoid arthritis; an audit against NICE guidance	• Audit of data collected from between October and December 2017, which involved 85 patients and 169 treatments; • Review of management against NICE and British Society of Rheumatology standards; • In comparison to the previous audit undertaken in 2015, there were improvements in hepatitis screening and in the discussion of infection risk with relevant patients. There is a need to improve the Disease Activity Score assessment (DAS - a measure of disease activity) and appointments for DAS are now routinely made at 4-6 months.
Anaesthetics - preoperative anaemia in patients undergoing hip and knee arthroplasty (replacement of joint)	• Evidence suggests that pre-operative anaemia is associated with poor clinical outcomes; • Specialty has developed a peri-operative IV iron service within PREP which is unique in the region and allows rapid correction of iron deficiency anaemia in patients undergoing major surgery for both urgent and elective cases; • Audit shows a reduction of transfusion rates for total knee / hip replacements (TKR/THR) from 7.4% to 1.7%; • Length of stay has fallen for both TKR and THR patients by over 1 day; • Patient feedback has been excellent and we have reduced the requirement for transfusion in colorectal, urology, gynaecology as well as orthopaedic surgery.
Emergency Department (ED) - Reducing time to CT scan for head injuries	• Quality improvement project focused on reducing the interval between the arrival of a patient with head injury into ED and completion of a CT scan; • The project reviewed the 'flow' of head injured patients through their journey to their CT scan, • The ED team introduced a number of changes to help improve the flow for patients, i.e. introduced an electronic triage tool for staff, produced lanyard aid memoirs for the medical and nursing staff and displayed posters in clinical areas; • The revised process has started to reduce the time patients wait for a CT scan following head injury.

Research and Innovation

City Hospitals Sunderland is committed to providing quality healthcare which is supported by research and innovation. We have had another busy and exciting year as we continue to build our partnership with South Tyneside NHSFT and the integration of our research and innovation teams across the Healthcare Group.

Mr Kim Hinshaw is Clinical Strategic Theme Lead for financial resources for the National Institute for Health Research, Clinical Research Network North East and North Cumbria (NIHR CRN NENC) and is a member of their Executive Committee. A number of City Hospitals Sunderland consultants are also appointed to Specialty Group Lead (or Deputy Lead) roles for some of the 30 clinical specialties. Mrs Deepali Varma is Specialty Group Lead for Ophthalmology; Dr Nimantha De Alwis is Specialty Group Lead for Diabetes, Dr David Coady is Specialty Group Lead for Rheumatology; Mrs Yitka Graham is Specialty Group Lead for Health Services and Delivery Research and Public Health; Mrs Amna Ahmed is Deputy Specialty Group Lead for Reproductive Health and Childbirth; Dr Sean Cope is Anaesthetic Specialist Group Lead, and Mr Neil Jennings has the role of Surgery (Endocrine and Upper GI) Sub Specialty Lead.

Research nurses Eileen Walton and Steve Dodds have also recently been awarded 'Greenshoot' research sessions to support them in Principal Investigator roles.

We have appointed two Patient Research Ambassadors (PRA), Mrs Valerie Bryant and Mrs Dorothy Peacock who have joined our longstanding PRA, Mr Steven Hogg. They have been involved in initiatives which aim to raise awareness of the benefits of research participation and are involved in planning a cross-unit Clinical Trials Day to be held May 2018. We aim to add to the team by appointing more PRAs to promote and increase research awareness across both Trusts.

The Obstetrics and Gynaecology Research Team has been recognised for increasing their patient recruitment this year and have actually been the highest recruiters nationally for several studies with numbers above those achieved by units more than double their size. Dr Scott Marshall (Haematology), Dr Min Myint (Stroke), Dr Shahid Junejo (Cardiology), Mr Arullendran Puveendran (Head and Neck), Mrs Deepali Varma and Mr Jonathan Smith (Ophthalmology) have all been awarded Certificates of Achievement from the NENC CRN for ensuring recruitment to time and target for commercially-sponsored studies, which is a high priority nationally. Sunderland Eye Infirmary has recently received two Ophthalmology Honours national awards; winner of the 'Judges' Special Award 2017' for 'High Quality Clinical Research' using a collaborative team approach, with Research Nurse Steve Dodds receiving a National High Commendation.

2017/18 has been a successful year for the Trust in terms of innovation with four shortlisted entries in this year's Bright Ideas in Health Awards across three categories:

1. Most Innovative NHS Education Provider (*South of Tyne SimMom® Maternity Training Collaborative***-** Mr. Kim Hinshaw- Consultant Obstetrician and Director of Research and Innovation and Denise Mace- Senior Midwifery Lead CHSFT as well as academics from the University of Sunderland);
2. Innovative Technology or Device Category (*Laboratory Sample Storage*- Andrew Turner- Lean Innovator CHSFT, Quality Hospital Solutions and Charlotte Fox- Innovation Manager CHSFT as well as laboratory staff from Gateshead Health NHS Foundation Trust); and
3. Outstanding Industry Collaboration with the NHS (*Tookie Vest* for Renal, Dr Saeed Ahmed- Consultant Interventional Nephrologist CHSFT, Dr Rachel Davison- Consultant in Renal Medicine CHSFT, Debbie Sweeney- Vascular Access Specialist Nurse CHSFT, Paul Corrigan- Research Nurse CHSFT and the SME Tookie Ltd & *Improved Test for Bladder Cancer* Mr. Stuart McCracken- Consultant Urologist CHSFT and Sue Asterling - Urology Research Nurse CHSFT and other collaborators from NHS organisations across the country and Sunderland based SME Arquer Diagnostics Ltd).

The Trust won first prize for the Quality Hospital Solutions Laboratory Pallet - a collaborative project between the South Tyneside and City Hospitals Sunderland Healthcare Group and Gateshead NHS Foundation Trust's pathology department.

Mr. Stuart McCracken has led a successful collaboration with Sunderland based company Arquer Diagnostics with the assistance of Research Nurse Sue Asterling to develop and evaluate a non-invasive assay to detect bladder cancer. The collaborative project won first prize for outstanding collaboration with industry. Our consistent success at the annual 'Bright Ideas in Health' awards, which celebrate the achievements of individuals and teams working within the NHS, industry and academia, and other accolades received by staff are an endorsement of our commitment towards innovation in healthcare.

Dr Saeed Ahmed and the renal team saw their hard work and effort with Tookie Ltd recognised regionally and nationally by being successfully selected for the Venture Fest North East Innovation Showcase 2017. The vest, designed by patients for patients to enable them to live a better quality of life by securing a central venous catheter in place, required for haemodialysis, is now being manufactured to be evaluated formally with patients in the NHS. The City Hospitals Sunderland Shoulder Bench designed and produced by Dr Ala Mohammed has been implemented in the Emergency Department with fantastic results. Dr Philip Dowson has led the project which has seen a 29% reduction in time to discharge, 41% less procedural sedation required for patients, 34% reduction in time to successful treatment and 6 week reduction in specialist follow up.

This year the Innovation Department launched a series of innovation showcases to span the healthcare group to encourage staff to come to us with the bright ideas and for academia and local companies to collaborate with us in solving unmet needs within healthcare. With generous support from the Academic Health Sciences Network (AHSN) we are committed and passionate about making a difference to innovation, health and wealth within our economic region. We continue to work with universities across the region and have several collaborative projects underway. We have a formal partnership with the University of Sunderland and are in the process of formalising a relationship with Teesside University.

The number of patients receiving relevant health services provided or sub-contracted by City Hospitals in 2017/18 who were recruited during that period to participate in research approved by a Research Ethics Committee was 2540. There are currently 240 research studies approved by the Health Research Authority (National Research Ethics Committee) registered at City Hospitals Sunderland, 37 are industry sponsored studies recruiting 307 participants of the total 2540.

Throughout 2017/18 the Research, Development and Innovation teams from Sunderland and South Tyneside have worked closely together with an aim to be an integrated team by 1st April 2019. There is confidence that an integrated team will provide increased opportunity and expansion for Research and Innovation. Both Trusts offer different strengths which complement one another. Sharing the success and expertise will undoubtedly further strengthen the position of the integrated team as a leader in research across North East and North Cumbria.

A joint event was held in May 2017 in recognition of International Clinical Trials Day. The event attended by approximately 100 patients and staff, was held at City Hospitals Sunderland and was aimed mainly at the public. The day was a great success with positive feedback and a similar event will be held in 2018.

A joint Research, Development and Innovation meeting structure has been agreed. Going forward these meetings will oversee the development of our integrated Research and Innovation team. As previously mentioned, we are developing an integrated five year Research Strategy. This will clearly outline the key aims and objectives for research and innovation across both Trusts for the future.

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 2017/18 was conditional on achieving quality improvement and innovation goals agreed between City Hospitals Sunderland and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at www.chsft.nhs.uk.

For 2017/18, approximately £6.3m of income (£6.25m in 2016/17) was conditional upon achieving quality improvement and innovation goals through the CQUIN framework. The Trust achieved the majority of these quality goals and has received a monetary total of £6.07m (96%) (£5.86m in 2016/17) for the associated payment in 2017/18 relating to delivery of these schemes.

The full CQUIN scheme 2017/18 and where we have achieved our targets are highlighted below:

No	Topic	Indicator	Priority	Achievement*
1	Improving the health and wellbeing of NHS Staff	Improvement of health and wellbeing of NHS staff	National	
		Healthy food for NHS staff, visitors and patients		
		Improving the uptake of flu vaccinations for frontline clinical staff		
2a	Reducing the impact of serious infections	i) Timely identification of patients with sepsis in the emergency department ii) Timely identification of patients with sepsis who are inpatients	National	
2b		Timely treatment of sepsis in emergency departments and acute inpatient settings		
2c		Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours		
2d	Reduction in antibiotic consumption	i) % of antibiotics by DDD** per 1,000 admissions	National	
		ii) % of carbepanem by DDD per 1,000 admissions		
		iii) % of piperacillin-tazobactam by DDD per 1,000 admissions		

3	Improving services for people with mental health needs who present to A&E	Improving services for people with mental health needs who present to A&E	National	

4a	Advice and guidance	Proportion of services available	National	
4b		Proportion of responses within 2 days		
4c		Proportion of responses within 5 days		

5	e-Referral	e-referrals	National	

6	Supporting proactive and safe discharge	Supporting proactive and safe discharge	National	

* based on indicative position to be agreed with Sunderland Clinical Commissioning Group **DDD defined daily dose

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 and 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 2017/18.

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 in September 2014 as part of their planned inspection programme. The CQC visit included services at Sunderland Royal Hospital, Sunderland 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 Hospital Requires Improvement
- Sunderland Eye Infirmary Good

Following the visit improvement actions were agreed at the Quality Summit in January 2015. The action plan has been reviewed at regular intervals by the Governance Committee and Executive Committee. In view of the progress made and evidence of robust monitoring in place the action plan was considered as being complete in November 2016. Late 2017, the Trust was notified by the CQC that it would be undertaking a three day announced well led inspection in the Spring 2018. Furthermore, they also advised that an unannounced inspection of core services will take place prior to the announced visit. The outcomes of both visits and the actions taken by the Trust will be summarised in next year's Quality Report.

Care Quality Commission Mortality Alerts

In May 2017, the CQC issued a formal mortality alert to the Trust which showed a higher than average mortality rate for pneumonia. An investigation report sent in response detailed the outcomes from the Trust Mortality Review Panel and those cases which had been subject to review and evaluation of the patient's management. The report included an action plan which highlighted areas requiring some improvement, for example, the need for appropriate counter-signing of DNACPR forms on admission by the senior clinician and completeness of relevant documentation after death. The original action plan was amended slightly following feedback from the CQC which also suggested that the local inspection team should follow-up on progress with implementation.

In November 2017, the Trust received notice from the CQC that they were now happy to formally close the pneumonia mortality alert in view of the progress made and assurance given. This notice of closure was also extended to a previous alert around intestinal obstruction. The information was shared with our Commissioners. At the time of reporting the Trust is in a position of having no active, 'open' mortality outlier alerts.

NHS Number and General Medical Practice Validity

City Hospitals Sunderland submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

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	99.9%
Percentage for accident and emergency care	99.5%	Percentage for accident and emergency care	99.9%

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

- daily NHS Number batch trace process in place with manual validation of daily exceptions;
- all staff who register new patients now have access to the National Spine and are trained how to search for the NHS Number to always enter a complete record. This is monitored closely by the Data Assurance team;
- a daily report is generated to determine the NHS number for patients attending the Emergency Department. This is checked against the Spine and entered retrospectively by the administration staff;
- The Data Quality team run weekly Master Patient Index reports and manually search and populate any records with blank NHS Numbers;
- 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; and
- prior to national data transmission, the Data Assurance team '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 prior to submission.

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 has completed a review of all evidence against the IG requirements within the Toolkit. Each requirement is scored from level '0' (i.e. worst) to level '3' (best). The final submission of the Toolkit was made by 31 March 2018.

City Hospitals Sunderland's Information Governance Assessment Report overall score for 2017/18 was 85% and was graded Green (satisfactory). The breakdown of the level scores is highlighted below. This shows that of the 45 requirements, 45 were assessed as being at Level 2 or Level 3. In detail:

- 19 show evidence that complete to Level 2;
- 26 show evidence to Level 3.

The IG Toolkit has been substantially revised and updated, and from April 2018 will be known as the 'Data Security and Protection (DSP) Toolkit'. The emphasis of the new DSP Toolkit will be on organisational compliance with the National Data Guardian's 10 Data Security Standards, compliance with the General Data Protection Regulation, and ensuring Cyber Security within the organisation.

Quality of data - Clinical coding error rate

From 2016/17 the clinical coding audit programme has applied a new methodology and there is no longer a standalone 'coding audit' with error rates as envisaged by the regulations. Therefore, City Hospitals Sunderland was not subject to the Payment by Results clinical coding audit during 2017/18.

Statement regarding how City Hospitals is implementing the priority clinical standards for Seven Day Services

The Seven Day Services programme is designed to ensure patients that are admitted as an emergency receive safe, high quality, consistent care, whatever day they present at hospital. In 2013 the NHS Seven Days a Week Forum developed ten clinical standards describing the minimum level of service patients admitted through urgent and emergency hospital routes should expect to receive, on every day of the week.

With the support of the Academy of Medical Royal Colleges (AoMRC), four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

Standard 2: Time to first consultant review
Standard 5: Access to diagnostic tests
Standard 6: Access to consultant-directed interventions
Standard 8: On-going review by consultant twice daily for high dependency patients, daily for other patients.

In line with the Government's Seven Day Services agenda, all trusts must meet the four priority standards by 2020.

Our vision

Our vision for Seven Day Services is to provide and deliver a more responsive and equitable service across seven days at City Hospital Sunderland. A robust implementation plan has been developed to support delivery of the four priority clinical standards within affordable plans, in line with the national perspective.

What we have done in 2017/18

- The Trust has participated in all five national Seven Day Services surveys (last survey autumn 2017).
- Summary reports have been provided to Divisional General Managers and Clinical Directors to highlight local analysis of survey results and areas for ongoing action and improvements.
- Attended and participated in national Seven Day Services events to support development against the four priority standards.
- Participated in regional Action Learning sets chaired by NHS England/NHS Improvement to share learning and peer support on Seven Day Services improvements.
- Strengthened our clinical leadership to support delivery of the clinical standards.
- On-going operational level improvement work to support patient flow and experience. Internal and external response standards have been developed which include the four priority standards. These are embedded into daily board and ward rounds to support effective flow of patients through our hospital. These response standards support staff in identifying when to escalate delays i.e. *if no consultant review has taken place*.

City Hospitals Sunderland - Results against 4 priority standards

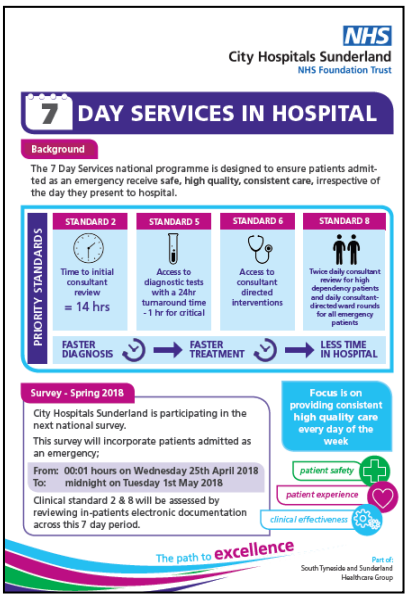
		Sept 2016	March 2017	Sept 2017	Target
Standard 2 First consultant review within 14 hours of admission	*Weekday*	74%	70%	66%	90%
	Weekend	69%	59%	58%	
	Overall	**72%**	**67%**	**64%**	
Standard 5 Diagnostics	*Weekday*		100%	NOT Measured	90%
	Weekend		100%		
	Overall		**100%**		
Standard 6 Interventions	*Weekday*		100%	NOT Measured	90%
	Weekend		89%		
	Overall		**94%**		
Standard 8 – Ongoing daily reviews					
Once daily reviews*	*Weekday*	99%	99%	NOT Measured National focus on Standard 2	90%
	Weekend	74%	91%		
	Overall	**93%**	**97%**		
TWICE daily reviews*	*Weekday*	100%	100%		90%
	Weekend	100%	100%		
	Overall	**100%**	**100%**		

***A clinical judgement is used to determine the frequency of consultant review required for each patient in the survey.** All patients with high dependency needs should be seen and reviewed by a consultant **TWICE DAILY** (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least **ONCE EVERY 24 HOURS**, seven days a week, unless it has been determined that this would not affect the patient's care pathway.*

The Trust has met three out of the four priority standards in March 2017 (*last full survey against 4 priority standards*). Our results show that further improvements against standard 2 are required in order to achieve all four priority standards.

- The fifth national survey was undertaken in September 2017. Focus for this survey was only against clinical standard 2, as this is the standard that is the least well achieved nationally. Results show a further slight decrease for standard 2 to 64% overall (*67% March 2017*). All results demonstrate a variation between weekday and weekend.
- Analysis of survey results have been shared with key clinical leads to agree improvements to help progress towards achievement of all four standards.

Plans for 2018/19



- Since our last survey the organisation has undertaken a phased programme of work to move to electronic inpatient documentation. As a result of this work we are working closely with our IT/Informatics colleagues to build a report to extract consultant assessments across inpatient specialty areas. This will allow the Trust to monitor assurance going forward.
- We are linking with a comparable size hospital which is succeeding in the move to achieve the four priority standards.
- Ongoing national discussions are taking place around key specialty services i.e. Paediatric pathways.
- Priority standards are being included in the Path to Excellence Clinical Service reviews.
- Engaging with junior doctors to support our next survey planned for spring 2018.
- Ongoing clinical leadership and frontline staff engagement - collaboration between clinical and operational leadership teams and other frontline staff engagement around the four priority standards.

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. For each indicator the number, percentage or scores 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 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 15 – Sept16	Jan 16 – Dec 16	April 16 – March 17	July 16 – June 17	Oct 16 – Sept 17
Month of release	Mar 17	June 17	Sept 17	Dec 17	Mar 18
City Hospital's SHMI	1.00	1.00	1.01	1.01	0.98
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*)	1.16	1.19	1.21	1.23	1.25
Lowest SHMI value – national (*low is better*)	0.69	0.69	0.71	0.73	0.73

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 15 – Sept16	Jan 16 – Dec 16	April 16 – Mar17	July 16 – June 17	Oct 16 – Sept 17	Oct 15 – Sept16	Jan 16 – Dec 16	April 16 – Mar17	July 16 – June 17	Oct 16 – Sept 17
Trust	1.3	1.3	1.2	1.2	1.2	17.3	16.5	16.0	15.2	15.5
National average	1.5	1.6	1.6	1.6	1.7	29.6	29.9	30.5	30.8	31.5
Highest national	3.7	3.8	3.8	3.5	3.3	56.3	55.7	56.6	58.3	59.5
Lowest national	0	0.2	0.5	0.6	0.7	0.4	7.3	11.1	11.2	11.5

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

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

- Trust mortality data is submitted in accordance with established information reporting procedures;
- To date, the SHMI for the Trust has remained consistent and not subject to significant variation. The Trust continues to view this in line with internal scrutiny of data quality; and
- SHMI data is provided through NHS Indicators and is formally signed off by the Medical Director.

The Trust acknowledges the low rate of palliative care coded at diagnosis level and is working with coding and palliative care colleagues to ensure that rates going forwards reflect the Trust's activity levels. This is being monitored closely and discussed quarterly at the Trust Mortality Review Group chaired by the Medical Director.

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:

- Mortality cases are routinely reviewed by a Consultant-led Trust Mortality Group. The fundamental reason for undertaking reviews is to identify any cases of potentially avoidable mortality, formulate action plans and disseminate learning. Themes and trends are highlighted and have led to demonstrable quality improvements; and
- Consideration of the recommendations made by the CQC in its review of the way NHS trusts investigate the deaths of patients in England – *Learning, candour, accountability* – and how these are integrated into local processes.

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' 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	2017/18 Adjusted average health gain	National England average 2017/18
Hip replacement	0.394	0.429	0.404 (P)	**	**
Knee replacement	0.331	0.334	0.312 (P)	**	**
Varicose vein procedures	0.079	0.075	0.044 (F)	**	**
Groin hernia procedures	0.054	0.045	0.063 (F)	**	**

Data source – NHS Digital – Dataset 18: PROMS

(P) Provisional data to be finalised August 2018
** Awaiting publication

City Hospitals Sunderland considers 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

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:

- continuing to monitor our rate of participation for each procedure and, although we have less direct influence, response rates are similarly reviewed. The Trust continues to raise awareness of the importance of returning the questionnaires at pre-operative assessment;
- actively participating in review of its results and work with NHS Digital and others to understand the data in order to inform understanding of patient outcomes, and
- investigating outlier PROMS performance to establish whether changes in the patient pathway are required.

(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
2017/18*				
0-15 years	6.42%	10%	19%	0%
16 and over	17.14%	17%	21%	10%
2016/17				
0-15 years	7.66%	12%	22%	0%
16 and over	25.25%	23%	32%	0%
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 Methods Analytics 'Stethoscope' benchmarking system. This uses different inclusion and exclusion criteria for the indicator which explains the marked increases in values compared to previous years.
*April – Dec 2017

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

- The figures presented are from the Trust's electronic performance monitoring system in the absence of datasets from NHS Digital which have not been updated since December 2013.

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 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	2017/18
City Hospitals Sunderland	68.9	64.4	68.8	68.1	63.8	Due June
National average	68.1	68.7	68.9	69.6	No longer published	No longer published
Highest national	84.4	84.2	86.1	86.2	No longer published	No longer published
Lowest national	57.4	54.4	59.1	58.9	No longer published	No longer published

Data source - National Adult Inpatient Survey 2017 (Care Quality Commission)

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

- the Trust sample varies from year to year and difference in outcomes is to be expected; and
- 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.

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

- monitoring of local and national patient survey results by the Trust's Patient, Carer and Public Experience Group and Committee;
- Implementation of the patient experience priorities within the Quality Strategy 2018-2023; and
    - listening and learning from patient experiences via the Patient Experience Survey and taking action where necessary.

(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)	2014	2015	2016	2017	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"*	65%	70%	70%	71%	70%	86%	47%

Source – NHS Staff Survey 2017 (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 2017 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 and Family Test and the NHS Staff Survey and using the additional information obtained make changes to the work environment for all staff when possible;
- 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 and communicated through staff briefing sessions;
- improving the quality of leadership and line management through targeted learning and support;
- improving staff health and well-being through a range of health-promoting initiatives;
- improving the quality of staff appraisals and non-mandatory training and education;
- involving staff in the implementation of the Trust Quality Strategy and its work stream framework; and
- embedding our Trust vision, values and behaviours in key people processes such as staff recruitment, appraisal, learning and development.

Last year, two additional indicators from the NHS Staff Survey were required to be included in Quality Reports. We have provided the scoring for these specific indicators again which show very little change:

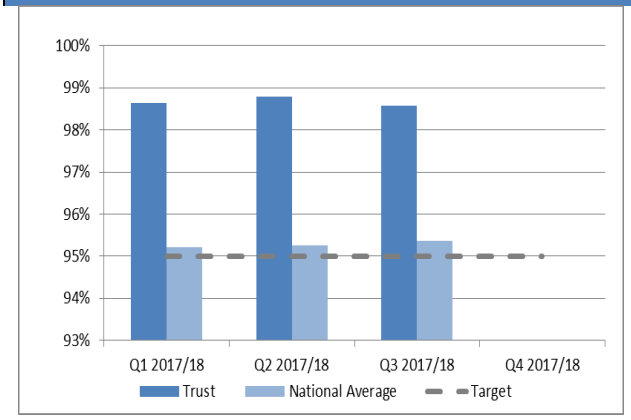
Indicator (Acute Trusts only)	2014	2015	2016	2017
KF21 – Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion *(higher score is better)*	88%	89%	87%	87%
KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(lower score is better)*	18%	21%	20%	21%

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 show 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 2017/18	98.64%	95.20%	51.38% - 100%
Q2 2017/18	98.79%	95.25%	71.88% - 100%
Q3 2017/18	98.57%	95.36%	76.08% - 100%
Q4 2017/18	**	**	**

2014/15 (97.61%)	2015/16 (98.28%)	2016/17 (98.50%)

Data source NHS England - https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201718/

** Data not yet published, expected June 2018.

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

- the Trust has maintained compliance with the 95% NHS Standard Contract threshold. This compares favourably and indicates that clinicians are completing VTE risk assessments with appropriate VTE prophylactic measures.

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

- strengthening the process of clinical review of all cases of hospital acquired thrombosis to see if any changes to VTE practice needs to take place;
- exploring opportunities to work closely with South Tyneside NHSFT in a joint 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;

(ii) Rate of *Clostridium difficile* infection

Clostridium difficile, also known as *C. difficile* or *C. diff*, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others. *C. difficile* infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

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)*				
	2014/15	2015/16	2016/17	2017/18
City Hospitals	18.7	29.2	12.8	**
National average	15.0	14.9	13.2	**
Highest national	62.2	66.0	82.7	**
Lowest national	0.00	0.00	0.00	**

Source – NHS Digital Indicator Portal

* Some of the data values have changed following final publication of the data and therefore may be different to those previously published

** Data not yet available, expected in June 2018.

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;
- promoting high standards of staff and patient hand hygiene, environmental cleanliness and the continued vigilance and awareness of staff; and
- undertaking root cause analysis of all hospital acquired cases in order to ensure opportunities to improve practice are identified and acted upon.

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

All Trusts have a responsibility to ensure 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 2017). This data is based on incidents submitted to the National Reporting and Learning System by the 30 November 2017.

CHS reporting	Rate*	National average	Highest national	Lowest national
1 April 2017 – 30 September 2017	49.78	42.8	111.7	23.5
1 October 2016 - 31 March 2017	49.95	42.8	88.2	11.2
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

Source – Organisation Patient Safety Incident Reports (acute – non specialist) via NHS Improvement (latest data published 21st March 2018)
* Incidents reported per 1,000 bed days

Incidents reported by degree of		City Hospitals	National average	Highest national	Lowest national
1 April 2017 – 30 September 2017	Severe Harm	4 (0.1%)	0.3%	1.5%	0.0%
	Death	0 (0%)	0.1%	0.5%	0.0%
1 October 2016 - 31 March 2017	Severe Harm	6 (0.1%)	0.3%	2.1%	0.0%
	Death	0 (0%)	0.1%	0.5%	0.0%
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%

Source – Organisation Patient Safety Incident Reports (acute – non specialist) via NHS Improvement (latest data published 21st March 2018)

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

- consistent reporting of all patient safety incidents to the National Reporting and Learning System (NRLS) against each of the required six month periods;
- the Trust is in the upper quartile of reporters for the last four reporting periods. According to the National Reporting and Learning System, organisations that report more incidents usually have a better and more effective safety culture; and
- an open and engaged culture to learn from incidents and improve the quality and safety of services.

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 initiatives and frequent 'Lessons Learnt' seminars accessible to all hospital staff;
- maintaining and improving an open and transparent reporting culture, one which encourages all healthcare staff to report all adverse events and near misses; and
- appointment of a Freedom to Speak Up Guardian and a network of Ambassadors to provide confidential, independent advice and support to staff in relation to concerns about patient safety, care and treatment.

PART 3: OTHER INFORMATION – REVIEW OF QUALITY 2017/18

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.

		Indicators	Target	Rating
	Patient Safety	Reduce the number of patient falls that result in serious harm	To sustain our position of being below the regional and national averages	
		Improve the reporting and investigation of hospital associated venous thromboembolism (VTE) events	To strengthen the investigation and lessons learnt processes for cases of hospital acquired thrombosis	
		Improve the completion, documentation and visibility of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders	10% improvement by Quarter 4	
	Clinical Effectiveness	Improve the process of fluid management and documentation	To increase the percentage for each element of the annual assurance audit	
		Improve the assessment and management of patients with sepsis	- 90% of patients who are screened for sepsis according to local protocol - 90% of patients who receive antibiotics within 1 hour - 90% of patients who have an empiric review (of their antibiotics) within 24-72 hours	
		Reduction in the number of avoidable (predictable) cardiac arrests	Improvement of 5% for 2017/18	
	Patient Experience	Reducing cancellations of outpatient consultations	10% reduction during 2017/18	
		Improve the timeliness of response to patient complaints	To consolidate improvement made in 2016/17	
		Increase the % of patients who reported they had a positive experience (Q72 - Overall……..)	Improve overall score against 2016 performance in the national adult in-patient survey 2017 (2016 = 7.9/10)	Data not yet published

3.1 Indicators for Improvement

Indicators for improvement	**Focusing on Patient Safety**

1 Reduce the number of patient falls that result in serious harm
Target - to sustain our position of being below the regional and national averages

All in-hospital patient falls are reported as an incident in the Trust's Incident Reporting System. Over the last 4 years the Trust has been consistently below the reported peer average for patients suffering harm from a fall in hospital. The agreed target for City Hospitals in 2017/18 was to sustain this position of being below the regional and national average for patients suffering moderate or above harm from a fall in hospital. The Trust's Hospital Falls Reduction Group is leading on this quality priority. The purpose of the group is to oversee the implementation of guidelines for the prevention and management of in-patient falls within the Trust.

The data for 2017/18 is presented in the table below and is sourced from the Trust Ward Dashboards. This shows the incidence of in-hospital falls each month and the rate of falls per month using the metric 'rate per 1,000 occupied bed days'. Please note up until September 2017, the Falls Group only collected and reviewed data for falls resulting in

moderate or above harm (in line with the agreed Quality Priority). However, the group made the decision to expand this to include all falls, to include falls resulting in no harm or low/minor harm, as there are lessons to be learned in all cases, not merely those falls where the patient suffers significant harm.

	Apr 2017	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2018	Feb	Mar
Total No. Falls						103	124	120	138	158	115	136
Rate / 1,000 bed days – All Falls						**6.41**	**7.23**	**7.24**	**7.79**	**8.25**	**6.70**	**7.30**
No. Harm						66	77	86	93	107	75	78
Low Harm						35	46	34	42	50	39	57
Moderate Harm	0	0	1	1	1	2	1	0	3	1	1	1
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Death	1	0	0	0	0	0	0	0	0	0	0	0
Total No. Falls ≥ Moderate Harm	1	0	1	1	1	2	1	0	3	1	1	1
Rate / 1,000 bed days –Falls ≥ Moderate Harm	**0.06**	**0**	**0.06**	**0.06**	**0.06**	**0.12**	**0.06**	**0**	**0.17**	**0.05**	**0.06**	**0.05**

The national rate for falls with ≥ moderate harm = 0.19 / 1,000 bed days. Therefore, the data demonstrates the Trust has successfully maintained its position of being below the national average for patients suffering moderate or above harm from a fall in hospital.

Plans for 2018/19

- continue to reduce the incidence of patients suffering significant (moderate or above) harm from a fall in hospital, such that the Trust remains in the lower quartile of reporting Trusts nationally;
- participate in the next round of the Royal College of Physician's National Audit of Inpatient Falls; and
- the Hospital Falls Reduction Group will continue to monitor all falls data to learn lessons and drive improvements in relation to falls prevention and management within City Hospitals.

2 Improve the reporting and investigation of hospital associated Venous Thromboembolism (VTE) events Target - to strengthen the investigation and lessons learnt processes

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 Trust VTE Group introduced a revised clinically-led process for investigating all cases of hospital acquired thrombosis. The responsible consultant for each confirmed case completes a review of care and a judgement is made on whether the episode could have been prevented. The outcomes of cases, and any lessons learnt for the organisation, are presented at VTE Group meetings. The table below shows the number of completed reviews:

	2017									2018		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cases for review	4	4	10	3	3	3	2	5	9	Cases for review yet to be determined		
Actual cases reviewed*	2	3	5	3	1	1	1	2	5			

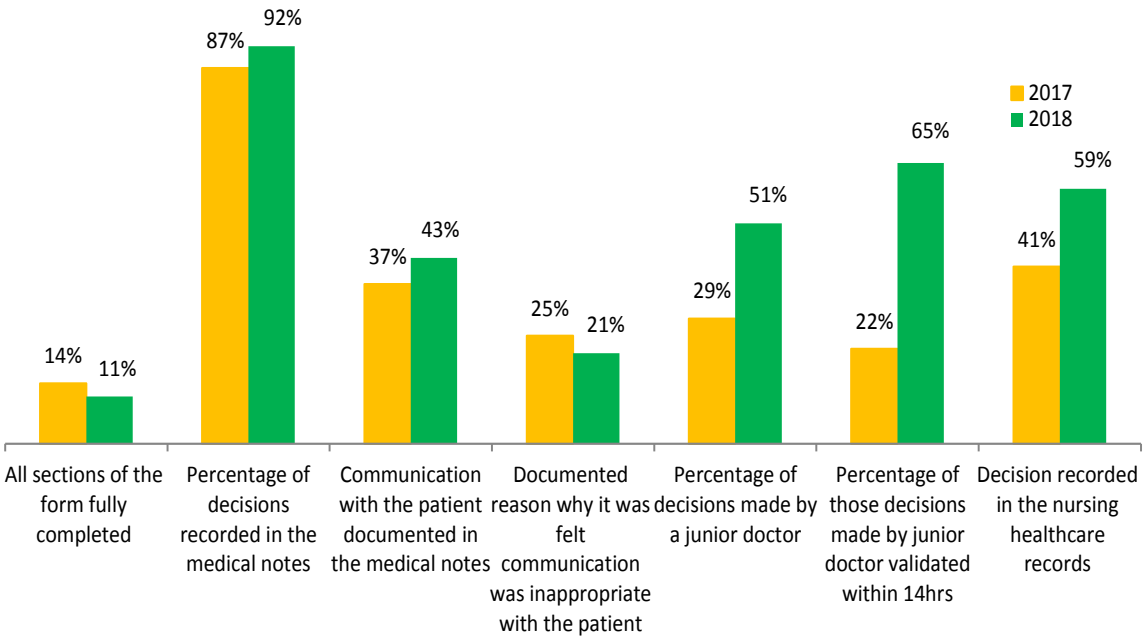
*cases reviewed and documentation returned as at 25th April 2018

The number of returned, completed case reviews to date is not as high as we would have hoped. It shows the need for further strengthening of our process and this will include raising awareness among senior medical staff and introducing a reminder system into the communications with medical teams to act as a helpful prompt. The VTE Group will also challenge in a supportive way those who are having difficulties completing these important reviews of care. In 2018/19 we will be working closely with those responsible for leading VTE in South Tyneside as a way to align and harmonise local VTE assessment and management practices.

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

3 Improve the completion, documentation and visibility of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders
Target – 10% improvement in 2017/18

The Resuscitation Team undertake audits of documentation in medical and nursing notes to assess whether all sections of the DNACPR form have been completed. This does not necessarily measure the effectiveness of the communication, only that it has taken place. The bar chart below shows a comparison of the completeness of DNACPR documentation in 2017 and 2018 across wards within the Divisions of Medicine and Surgery. In total, 538 inpatient records were reviewed and 158 patients had a confirmed DNACPR decision.



The most recent audit shows evidence of improvement for some individual elements but the most disappointing outcome is when looking at whether DNACPR forms are fully complete, and compliance with this standard remains stubbornly low. Further analysis shows where some sections of the form were not fully completed by clinical staff; such as basic demographic details, clear rationale for the DNACPR decision, aspects of communication with key people and appropriate medical staff signatures.

Actions that will be undertaken and / or reinforced with staff to address these documentation issues include:

- DNACPR information given to all junior doctors during induction;
- DNACPR procedural information available on the Trust intranet site for all staff to access;
- Explore the possibility of mandatory DNACPR training for staff. This initiative is currently being piloted in a number of clinical areas;
- Continue the cycle of audit and direct feedback to clinical staff; and
- Feedback at relevant Trust groups to highlight what procedurally can be improved. This will also provide the opportunity to strengthen the involvement of medical and nursing leads.

Duty of Candour

The Duty of Candour (DoC) is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or severe harm. DoC aims to help patients receive accurate, truthful information from health providers. 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 2017/18 the following incidents which require duty of candour have been reported:

	Q1	Q2	Q3	Q4
Incidents which require duty of candour 2017/18	8	8	10	2
Incidents which require duty of candour 2016/17	60	42	10	6

During the year, the Rapid Review Group has reviewed DoC practices and procedures in order to ensure they are clear and easy to follow and that there is an effective system for monitoring compliance. Guidance and reference documents have been provided to managers and governance leads to support practice as well as educational opportunities that has included:

- targeted training for Directorate Managers and all staff involved in incident investigation;
- presentations reinforcing the requirements of Being Open and DoC being delivered at specialty and directorate level governance groups and CG Leads Forum; and
- general awareness sessions delivered as part of the Trust scheduled Lessons Learned programme, which is open to all members of staff, that highlights their individual roles and responsibilities in the process. These sessions also used real case studies to demonstrate the effectiveness and benefits of the duty.

Never Events

Never events are serious and largely preventable. An updated list of never events is published by the Department of Health each year. This list includes a number of safety related incidents that should not occur if best practice guidance is followed. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident for that incident to be categorised as a never event. When a never event occurs it is essential to ensure learning takes place to mitigate any risk of a similar event occurring again. It is also important for the patient and/ or family affected to be kept fully informed and supported, in line with Duty of Candour.

The Trust declared 2 never events during 2017/18, but none of the patients came to serious harm or death. A brief description of what happened in each case is provided below:

Issue – Foreign body left in situ
A patient attended for Tenchkoff catheter exposure (a rubber tube used to drain fluid) under local anaesthetic. The interventionist was unable to expose the catheter as required as the plastic cover had been left in situ when the catheter was buried. The patient required a second incision which also extended the length of procedure. The patient was left with unnecessary scarring from this additional incision.

Lessons identified	Actions taken
• Technique for burying catheters is unique to Sunderland; and • Supervising consultant left theatre at the point where the catheter was being buried and the registrar was not aware that it was necessary to remove the cap.	• Improved supervision of junior doctors during procedures which involve specific SRH protocols; • Consultant and Registrar reflection and inclusion within their learning portfolios; and • Development of clear SRH protocols to facilitate junior doctor training in this procedure.

Issue - Wrong Site Surgery
The patient was booked for elective left middle finger release; the surgeon made a 10cm incision at the elbow in error. This was recognised immediately after the incision was made which was subsequently sutured and the correct procedure completed. The patient was discharged with scarring due to unnecessary incision.

Lessons identified	Actions taken
• All WHO check list processes and procedures correctly completed which should have prevented this incident; • All present in theatre including surgeon very clear that surgery was for the hand and not	• Surgeon to reflect and include this incident within his appraisal portfolio.

the elbow; and • Root cause of incident – human error	

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 complete its investigations. The Risk Teams work 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 tables below show the number of incidents logged onto StEIS by cause group and directorate. In total, 13 Serious Incidents have been declared by City Hospitals in 2017/18, this includes the two Never Events highlighted previously. This is a significant reduction on last year when we reported 35.

Cause Group	Number
Slips/Trips/Falls	4
Tissue Viability	3
Failure of handover (clinical)	1
Failure of follow up arrangements	1
Failure to act on observations/NEWS	1
Foreign body in situ	1
Wrong site surgery	1
Surgical/invasive procedures	1

Directorate	Number
Trauma and Orthopaedics	3
Rehabilitation and Elderly Medicine	3
Emergency Medicine	2
General Surgery	2
Head & Neck	1
Urology	1
Theatres	1

Indicators for improvement — Focusing on Clinical Effectiveness

1. **Improve the process of fluid management and documentation**
   Target – increase the percentage (%) for each element of the audit

The Trust's Nutrition Steering Group provides strategic leadership and co-ordination for all aspects of nutrition and hydration across the Trust to facilitate best practice and a positive patient, visitor and staff experience. A Task and Finish Group was set up to drive improvements in the recording and monitoring of patient's fluid intake / output.

In November 2017 a new fluid monitoring chart was implemented across the Trust, during FAB Change Week. This was accompanied by a standard operating procedure for fluid monitoring which had been ratified at Matrons Forum and Nutritional Steering Group. A re-audit was undertaken after the introduction of the new chart, with the following results:

	TOTALS		Comparator with previous audit (Sep 17)
	Number	%	
Number of patients included in audit:	119		
Does patient have a fluid balance chart?	89	74.8%	-5.7%
Any special instructions written?	26	29.2%	+11.6%
Chart completed fully over 24 hours?	60	67.4%	+5.9%
Drinking water available next to patient?	98	99.0%	-1.0%
If so, is drinking water within reach?	93	94.9%	-3.0%
IV infusions prescribed and given during time period?	16	14.3%	+0.9%
Were these IV infusions recorded on fluid balance chart?	5	31.3%	-55.4%
Output appears to be accurately recorded?	33	27.7%	-1.5%
Number where output not accurately recorded	56	47.1%	-14.4%
If no, is frequency of passing urine recorded rather than the volume?	49	87.5%	+1.8%
Balance box completed?	9	7.6%	-7.4%
Fluid balance summary chart in place?	35	29.4%	-5.1%
Does this cross check with fluid balance chart?	19	54.3%	+3.0%

The re-audit shows once again a mixed set of results and it is clear further work with clinical staff is required to fully embed the new requirements of the new fluid monitoring chart. During the audit, there was a switch from paper to electronic recording of IV fluids and therefore the result and value for this particular element of the audit is no longer accurate.

Plans for 2018/19

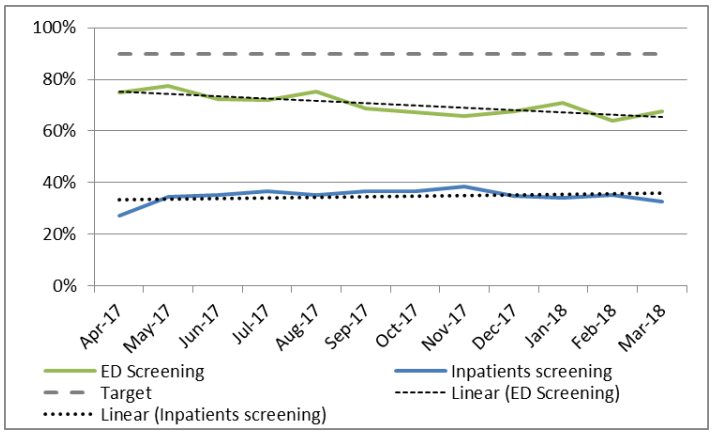
The Trust Assurance Team will review and amend the audit tool and undertake another audit during 2018/19. The Task and Finish Group will work with our Information and Technology staff to develop and pilot a fully electronic version of the fluid monitoring chart.

2. Improve the assessment and management of patients with sepsis

Sepsis is the body's extreme response to an infection. It is life-threatening, and without timely treatment, sepsis can rapidly cause tissue damage, organ failure, and death. The high death rate associated with sepsis is mainly due to poor identification and delayed intervention. Sepsis is part of CQUIN and guidance has been provided to hospitals to screen patients for sepsis and identify those who require rapid antibiotic treatment within 1 hour. The Trust has an electronic 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 CQUIN for 2017/18 are as follows:

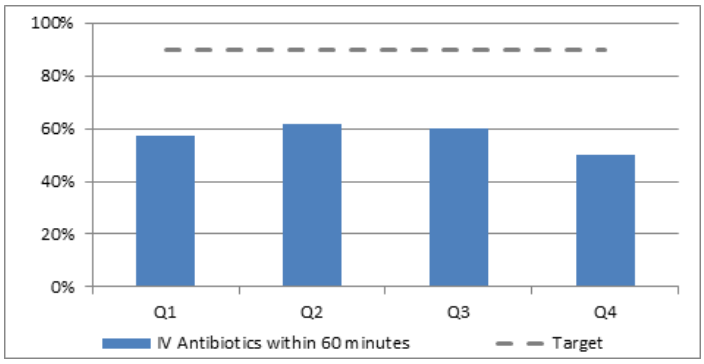
- 90% of patients are screened for sepsis (where clinically appropriate);
- 90% of patients are given intravenous antibiotics within 1 hour of arrival in the Emergency Department; and
- 95% of patients who receive antibiotics have an antibiotic review within 72 house of first administration.

Sepsis Screening - % of patients (adults & children) screened in the Emergency Department and in the In-patient Environment 2017/18



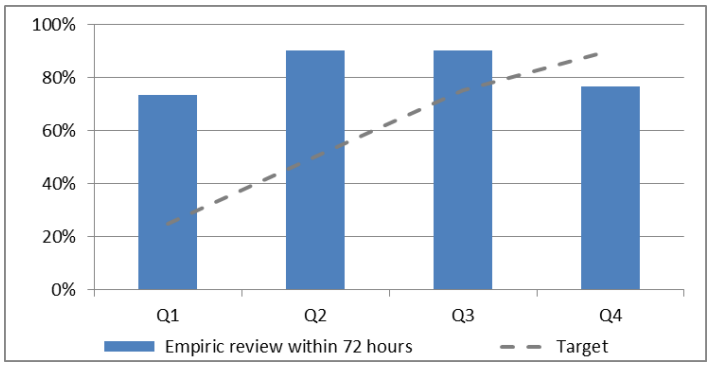
The Trust has been unable to maintain and improve performance within the Emergency Department. The downward trend shows the challenges faced by staff in this busy, demanding area, particularly over the winter period. There is a slight upward trend for the in-patients wards but it is still well short of the targets we want to achieve. The Trust Sepsis Group regularly monitors this performance and looks at ways to engage and support clinical staff in the process.

Rapid Antibiotic Administration - % of patients (adults & children) given antibiotics in the Emergency Department and Inpatient wards within 1 hour of arrival 2017/18



CQUIN recognises partial achievement as above 50% throughout the year and full achievement would be 90%. Whilst we were able to meet the partial achievement threshold throughout the year, we have further work to do to elevate performance to the higher 90% standards.

Antibiotic Review - % of patients (adults & children) with a senior antibiotic review in the Emergency Department and inpatient wards within 72 hours



The chart shows the Trust has achieved higher than the threshold of performance in all quarters except quarter 4. The decrease in reviews was due to winter pressures. Timely antibiotic review is important as it ensures patients are on the right drugs, the right dosage is given and at the most appropriate intervals.

What have we done this year?

City Hospitals Sunderland held a Trust wide event for World Sepsis Day 2017 (13th September). A number of activities were held which included; a month long competition to showcase the most improved and high performing wards (with regard to sepsis screening), various sepsis pledges signed by consultants and nurses and promotion of the importance of sepsis across social media.

In addition, the Trust has developed and been involved with:

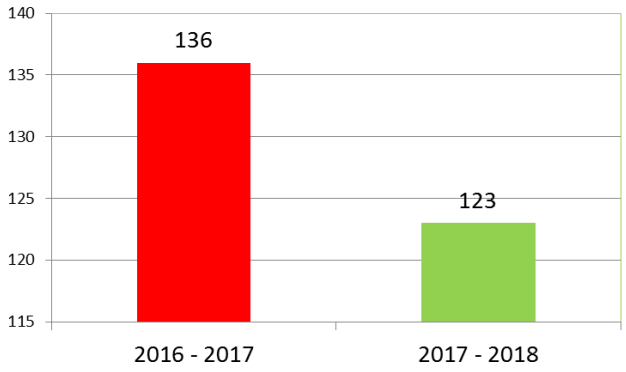
- Educational events on the importance of the 'Sepsis 6 bundle';
- Utilising the Trust Excellence Reporting system for highlighting wards with exceptional performance;
- Continuing our participation in the Regional Sepsis Group;
- Attended the Regional Deteriorating Patient Group as a mechanism for improving sepsis management for patients;
- Publicising a 'real-time' report wards can use to review sepsis screening performance and determine the course of action for each patient;

- Ensuring sepsis is included on the electronic status board on wards where this is available; and
- Holding regular meetings of the Trust Sepsis Group which is tasked to lead the strategic direction of sepsis management across the Trust.

During 2018/19, 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 continue to 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 provide a Trust-wide event in recognition of World Sepsis Day on 13th September 2018. This will likely involve our colleagues at South Tyneside NHSFT as we explore closer working between the two Trusts.

3. Reduction in the number of avoidable (predictable) cardiac arrests
Target - Improvement of 5% for 2017/18

When patients come into hospital they assume they are being monitored and that any deterioration in their condition will be detected and acted upon quickly. Unfortunately, this is not always the case and evidence has shown staff can, on occasions, fail to spot or act on changes in their condition. Some patients who deteriorate experience a cardiac arrest and a high proportion of these are predictable events. The goal was to reduce avoidable cardiac arrests through appropriate management of acutely ill patients.



Number of cardiac arrests (National Cardiac Arrest Audit)

The chart shows a **9.5%** reduction in the number of cardiac arrest events submitted to the National Cardiac Arrest Audit; this is a nationwide database of in-hospital cardiac arrest events which meet ALL the following criteria:

- the individual is an adult or child over 28 days;
- the resuscitation event commenced in-hospital;
- the patient received chest compressions(s) and/or defibrillation; and
- a 2222 cardiac arrest call was made and the individual was attended to by the hospital based resuscitation team.

The reasons for the reduction in cardiac arrest calls are complex but may in part be due to the appropriate use of NEWS (an early warning system for identifying acutely ill patients) and the earlier recognition and rapid response to deterioration. In addition, some wards and specialties have made progress in how they decide, document and communicate DNACPR decisions so patients are not subject to futile resuscitation attempts. Deterioration in acutely unwell patients can happened quickly with the corollary of cardiac arrest but in some patients this can be prevented through rapid recognition and timely treatment of their underlying medical condition.

Other Information - Reducing Healthcare Associated Infection

The Infection Prevention and Control Team (IPCT) has 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 2017/18 remained zero for MRSA bacteraemia. This has proven to be another significant challenge for the organisation. Nonetheless we reported only one case of MRSA

bacteraemia in 2017/18 which was deemed unavoidable and is a significant improvement on the five cases reported last year.

The IPCT continue to work closely with directorate teams to complete a detailed root cause analysis of each case of MRSA and Methicillin-susceptible Staphylococcus Aureus (MSSA) bacteraemia. There is currently no target for MSSA bacteraemia. Where lessons have needed to be learnt, these have been shared throughout the organisation, for example, ensuring staff consistently complete intravenous device assessments, that they always document the clinical reasons for having cannulas left insitu for longer than beyond 72 hours and reducing the incidence of contaminated blood culture samples. We will continue to drive improvement in these areas via our Healthcare Associated Infection (HCAI) Plan, 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 Sunderland in 2017/18 was 25. Following detailed examination of each case we have agreed via the appeals process with Sunderland CCG that 3 of these were not genuine infection or infections developing in hospital. Therefore, the Trust apportioned cases is confirmed at 22 against the target of 34 cases which is comparable 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 continue to form part of our HCAI Plan so that the organisation is focused on the appropriate infection prevention measures.

The IPCT can report a number of achievements during 2017/18, which include:

- the continued use of total room decontamination with hydrogen peroxide vapour or ultraviolet light which is known to be effective at reducing healthcare acquired infection;
- sustained screening of high risk patients who may have *C. difficile* colonisation;
- continued review and analysis of antimicrobial prescribing with particular reference to the 2017/18 antimicrobial stewardship CQUIN targets;
- increased engagement by IPCT staff with wards, departments and directorates;
- inclusion of peripheral cannula data on the IPC dashboard to monitor the success of infection prevention control measures and insertion, assessment and supporting documentation for cannulas that are left in-situ;
- introduction of root cause analysis for device related E. coli bacteraemia;
- significant contribution to the Trust flu vaccination programme
- the development of a multidisciplinary group to inform strategy for the reduction of gram negative bloodstream infections; and
- the development of a new care pathway for patients with diarrhoea.

Some of the key areas that the IPCT will be involved with next year include; working with NHS Improvement / NHS England to inform the strategy for the reduction of gram negative bloodstream infections. The target for this is 50% reduction from 2016 to 2021. The Trust multi-disciplinary group for management of IV devices will continue to deliver a strategy to reduce bloodstream infections with particular emphasis on training, audit and surveillance.

The IPCT remain committed to driving the strategies which promote safe, effective infection prevention and control practices across the Trust, working closely with clinical staff to inform and deliver a robust plan for the management of outbreaks and serious infections.

Indicators for improvement

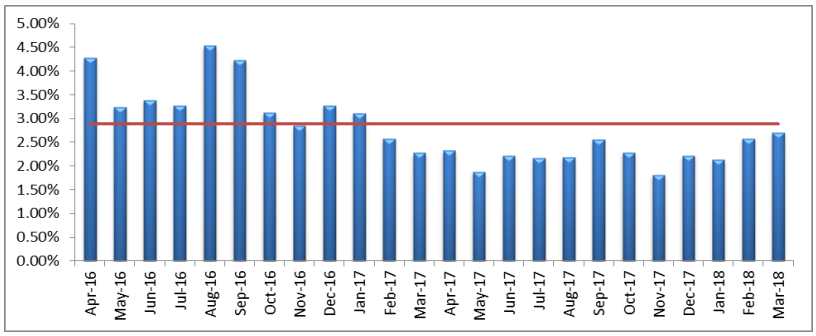
Focusing on Patient Experience

1. Reducing cancellations of outpatient consultations
Target – reduce the number of outpatient cancellations by 10% during 2017/18

This indicator was developed to reduce the number of outpatient appointments cancelled which impact patients. This builds on work undertaken as part of the Trust's scheduling improvement programme to provide efficient and effective outpatient services. The baseline cancellation rate was 3.21%, with a target set for a 10% reduction in 2016/17 and having achieved this at the end of that reporting period the same target has been extended in 2017/18.

Performance at Trust level for the 12 month period April 2016– March 2018 is shown in the chart below. Whilst the target has been reached in all of the last 12 months, increases in cancellations in February and March were due to the period of inclement weather.

The chart also shows the Trust has been achieving the target of 2.89% consistently.

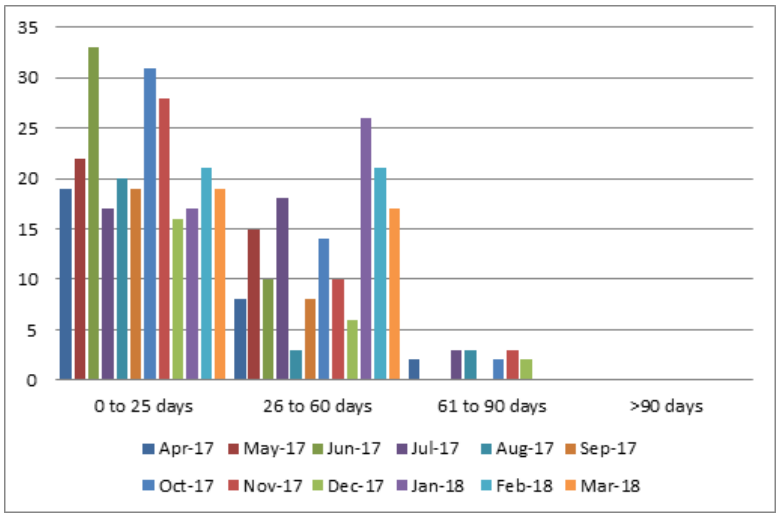


The target has been achieved due to a focus on ensuring that clinical teams plan more proactively with capacity and demand models now in place for the majority of specialties. It is now easier to see further ahead and plan for shortages of appointments so that we can better plan the service. This should reduce the number of cancellations due to annual leave and staff training. However, the consultant contract only requires 6 weeks' notice to be given by consultants and some services have longer waiting periods. It is more challenging to avoid cancellations in these services.

Further improvement actions planned for 2018/19 are:

- Monthly analysis is provided to Divisional General Managers, Directorate Managers and Scheduling Managers to identify shortcomings in processes leading to cancellations.
- A trial to protect some new capacity to better accommodate patients when they cancel or when the hospital cancels has proved successful. These processes are being applied in the other directorates. This will ensure patients can be rebooked within a reasonable timescale when we are unable to avoid the cancellation.

2. Improve the timeliness of response to patient complaints
Target – to consolidate improvement with the timeliness of response to patient complaints



The Trust recognised that a timely response to complaints will in many instances provide an effective investigation, learning of key issues and resolution for the complainant.

We aim to respond wherever possible to complaints within 25 working days and in the majority of cases within 60 working days, although we recognised that at times complaints are complex and that investigation and response times may be extended.

During 2017/18 no complainant waited longer than 90 working days for a response, in only a small number of cases the response time was beyond 60 working days and in many cases the response was received in less than 25 working days.

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

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 patient's 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 2017 survey is now 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 to 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; 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 2017/18 City Hospitals participated in the following national patient surveys;

Type of survey	Published
Adult Inpatient 2016	May 2017
Emergency Department 2016	Oct 2017
Child & Young Persons 2016	Nov 2017
Maternity 2017	Jan 2018
Adult Inpatient 2017	Due June 2018
Cancer Patient Experience Survey 2017 (in progress)	To be confirmed

Adult Inpatient Survey 2016

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.

The survey includes patients who were aged 16 years or over, who had spent at least one night in hospital during July 2016 and were not admitted to maternity or psychiatric units. Responses were received from 554 patients which is a response rate of 46% which is better than the national average. In terms of the findings, all 11 aggregated 'Section' scores are rated as 'Amber' (about the same as other Trusts). Out of the 65 individual questions measuring inpatient experience, the Trust achieved 60 (92.3%) scores in the 'as expected' category. There were 3 'worst' category rated questions relating to helping patients with their meals, the provision of privacy and information. However the Trust did achieve 2 'best performing' ratings around shorter delays in discharge than other hospitals.

Areas where scores have improved or remained the same as last year:

- The admission date for patients was less likely to be changed by the hospital in this year's survey;
- There have been some small improvements in patients' experience of the ward, i.e. less noise at night from hospital staff;

- Patients continue to feel safe in hospital;
- Patients continue to have confidence and trust in the medical staff looking after them and felt that neither doctors or nurses talked in front of them as if they weren't there; and
- Results show patients experienced shorter delays in discharge, particularly around waiting for medications, to see a doctor or waiting for an ambulance.

Areas where performance has declined from last year:

- Some patients felt that they wanted to be more involved in their care, or didn't feel that they had enough emotional support from staff during their stay. They also reported that they weren't given enough privacy when discussing their treatment;
- The findings show that sometimes patients didn't get answers from doctors and nurses that they could easily understand;
- Results for some questions that relate to patients' experience of being discharged from hospital have declined. Information about medications and their side effects was an area where there has been some deterioration. A smaller proportion of patients in 2016 said that their families were given all the information they needed before going home; and
- A greater proportion of patients said hospital staff did not discuss whether they might need any further health or social care services after leaving hospital even though they would have liked this to happen.

Our new Quality Strategy provides a framework for how we bring about improvements in patient experience. The work stream priorities will be monitored by the Patient, Carer and Public Experience Group which will report into the more strategic Patient, Carer and Public Experience Committee.

Emergency Department 2016

We asked patients about their recent contact with the Emergency Department

Patients who took part in the Care Quality Commission's national survey of Emergency Departments reported a number of improvements across the main survey themes. Responses were received from 302 patients who attended a Type 1 accident and emergency department (a major 24-hour department that is consultant-led) during September 2016 and were not staying in hospital during the sampling period. This gives a response rate of 33% which is much better than the national rate of 28%. The survey covered a range of areas, including: arrival at the emergency department, waiting times, doctors and nurses, care and treatment, diagnostic tests, the hospital's environment and facilities, leaving the emergency department, respect and dignity and overall experience.

City Hospitals achieved an 'about the same' rating for each of the 9 section scores. Out of 35 individual performance questions 32 (91.4%) were in the 'as expected' category, 2 (5.7%) were rated 'better' than other Trusts; both related to waiting times. There was only one question given a 'worse' rating and this was in relation to the lack of availability of food or drinks within the department. It is important to acknowledge that the Emergency Department was undergoing a huge structural rebuild during the fieldwork and the service had to be temporarily relocated into alternative accommodation. Undoubtedly, patient experience was affected during this difficult and challenging period despite the best efforts from staff.

Given this background, it is encouraging to see the majority of patients who attended our Emergency Department were positive about their experience and had confidence in the care they received. In particular the survey notes that patients;

- Experienced shorter waits in the department before being spoken to (90% of patients less than 60 minutes) or examined by a doctor or nurse (80% of patients less than 60 minutes);
- Felt they had enough time to discuss their health or medical problems with the clinical team (over 95% of patients said yes, definitely or to some extent);
- Felt confident and had trust in the staff that were looking after them (94% said yes, definitely or to some extent);
- Were given reassurance by staff if they felt distressed (82% said yes, definitely or to some extent);
- Reported that the department was clean (95% said very clean or fairly clean);
- Felt staff took into account the patient's family or home situation when leaving the department (63% said completely or to some extent); and

- Felt overall that they had had a good experience whilst in the department (94% said yes, all of the time or some of the time).

As previously highlighted, the structural changes to the build environment probably had an impact on some feedback. On some occasions our facilities didn't always meet the expectations of patients and their families all of the time. Our action plan to improve services has focused on matters of patient privacy, provision of information on delays, making sure conversations about the patient includes the patient, making sure everything is done to manage patients pain and explaining to patients what medication side effects to watch out for.

We are confident that with the opening of the new Emergency Department most of these will have been addressed and our scores will reflect a better patient experience in the future.

Children & Young People's Inpatient and Day Case Survey

We asked our children and young people to tell us about their experiences of hospital

The 2016 Children and Young People's Inpatient and Day Case survey asked about the quality of care for young patients in hospital during November and December 2016. It is made up of three separate questionnaires which capture the experiences of children at different ages and their family/carer experiences. Importantly, it specifically asks children and young people about their care, valuing their insight which can be different to the experiences of their parents and or carers.

Whilst there were many positive findings in the survey, for example in relation to information, communication, and staff interaction there were some areas that highlight where improvement is needed. The results also show some areas where experiences differ between different age groups, particularly around play and activities, and communications between healthcare staff and young patients.

Areas within the survey where City Hospitals did better than other hospitals:

- For most of their stay in hospital the child or young person was looked after on an appropriate children's ward;
- Before their child's operation or procedure, staff gave answers to questions that parents / carers could understand (for those 0-15 year old); and
- Parents / carers were given enough information about how their child should use their medications

The Trust did 'about the same' as other hospitals for making sure:

- Patients knew what would happen to them at the hospital;
- Patients liked the food;
- Someone at the hospital talked to patients about any worries they had;
- Patients had enough privacy when receiving care and treatment;
- Hospital staff helped patients with any pain they had;
- Someone from the hospital explained what would happen during the operation or procedure;
- Someone from the hospital told patients what to do or who to talk to if they were worried about anything when they got home;
- The people looking after patients were friendly; and
- Patients had a good overall experience of care in the hospital.

The Trust did have one score in the 'worst' category and relating to children and young people (aged 8-15 years) feeling that they weren't given explanations about what would be done before their operation or procedure. The full set of survey results and additional analysis of any comments provided by children and their parents or carer will be discussed and actioned within the specialty.

Survey of women's experiences of maternity services

We asked mothers about their experience of our Maternity Services.

Mums-to-be can be assured of excellent maternity care at Sunderland Royal Hospital, following the results of a national survey which measures patient satisfaction in the NHS. The 2017 national survey of 'women's experiences of

maternity care' has revealed City Hospitals Sunderland as the best performing Trust across the whole of the North East and North Cumbria when it comes to the care and attention women received in hospital after the birth of their babies.

Scoring the highest of any provider in the region for 'care in hospital after birth' maternity services at Sunderland Royal Hospital also scored amongst the very best in the entire NHS in two other key areas:

- Women feeling staff responded quickly if attention was needed after the birth of their babies; and
- Women feeling they received the information and explanations they needed after the birth of their babies

Some of Sunderland Royal Hospital's other highest scoring categories included:

- Partners being involved as much as they wanted (9.8 out of 10);
- Being treated with respect and dignity during labour and birth (9.5 out of 10);
- Staff introducing themselves before examination or treatment (9.4 out of 10);
- Being spoken to during labour and birth, in a way they could understand (9.6 out of 10); and
- Thinking the hospital room or ward was clean (9.3 out of 10).

Sheila Ford, Head of Midwifery at Sunderland Royal Hospital said: "We are very proud of the feedback we receive about our maternity service here at Sunderland Royal and this is testament to the hard work and dedication of our amazing teams who provide such high quality, compassionate care for women and their families on a daily basis. "The birth of a baby is such an important time and it is always reassuring to hear such positive feedback about the care women have received in hospital with us. There are, of course, areas where we must improve further and we will be looking at the results in detail, alongside other sources of feedback to the Trust, to make sure we continue to listen, learn and develop the very best maternity services for local women in our area."

Patient Experience Survey

Following introduction of the new Patient Experience Survey last year (poster opposite), we have continued to collect patient feedback across all our adult inpatient services using this design together with our well-established real time feedback questionnaire for Maternity Services, our Paediatric Wards and in our Intensive Care Unit.

Wards continue to be sent monthly reports highlighting their results, which include transcriptions of any additional free text comments. The results are also included in ward performance dashboards and are viewable to the public.

Altogether, we have received 8,533 completed patient surveys in 2017/18, which is only slightly down from last year (9602). The breakdown of individual survey groups are as follows:

- Patient Experience Survey (adult in-patients) – 7,808
- Maternity (real time feedback) – 180
- Paediatrics (parents) – 227
- Paediatrics (children) – 148
- Neonatal Unit – 97
- Integrated Critical Care Unit - 73

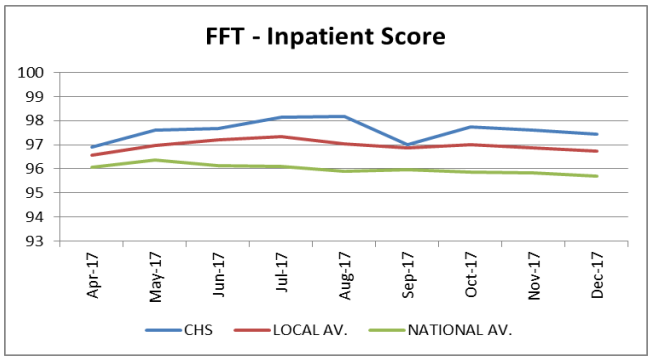
Patient Experience Collaborative

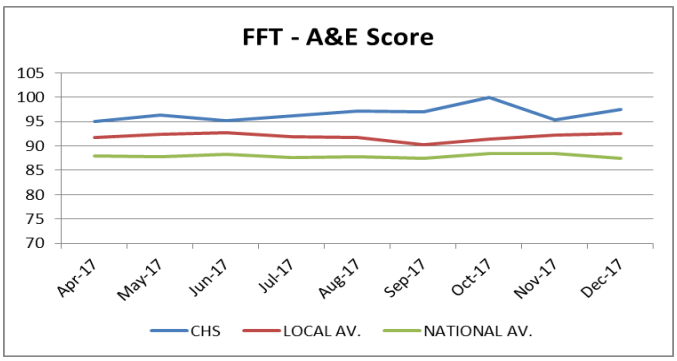
City Hospitals (together with South Tyneside NHSFT) have signed up to participate in a national collaborative led by the Patient Experience Network. The project will run for 12 months and the aim will be to collect patient experience

data from patients using a predetermined questionnaire. A number of wards across both organisations have been selected as pilot wards and the data collection, in the form of patient interviews, started in November 2017. Regular updates about our progress within the collaborative will be reported in the monthly Patient Experience Update.

Friends and Family Test

The Friends and 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 includes all our inpatient wards, including children and maternity, out-patients and day cases. The charts below show the patient scores (as a measure of whether they would recommend the hospital to family and friends) achieved in 2017/18 for adult in-patients and the Accident & Emergency Department. It shows performance above the national and local averages, although the response rates in both are below the national averages, which are in themselves low month by month.





There are no national targets for FFT response rates but nonetheless we have tried a number of ways to increase patient engagement in the process including; 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. The scores across the range of maternity services (Ante-Natal, Labour Ward, Post-Natal, Post-Natal Community) have remained consistently high during 2017/18 and either match or exceed national averages.

Benchmarking of satisfaction is reported to the Patient, Carer and Public Experience Committee on a quarterly basis. This report also includes a selected summary of patient comments; some examples are highlighted below:

What patients tell us was good about their care

- Nursing care was great. Even though they are extremely busy they find time to help and talk to you (*Orthopaedic ward*);
- All of the nurses helped as much as they could and made an extremely traumatic experience much more bearable. Nothing was too much trouble for them. Much appreciated (*Intensive Care Unit*);
- Very well looked after, staff very helpful in all aspects of care, dietary needs, and could not do enough. (*General Surgery ward*);
- Professionalism and dedication of the staff, they retained my dignity and privacy at all time (*Care of the Elderly Ward*);
- First class when I arrived I was in a terrible state so afraid that soon calmed after your staff took charge, I was all at once feeling safe (*Care of the*

What patients tell us could be improved

- Nothing medically but free TV would have been nice (*Gynaecology ward*);
- Maybe provide a hair net for surgery to prevent your hair from being dyed green!? (*General Surgery ward*);
- Disturbed by rapid response cleaning team through the night (*General surgery ward*)
- More staff needed. Could have done with more visits from physio (F61);
- Wearing a gown instead of pyjama's (*Care of the Elderly ward*);
- Staff doing one thing at a time rather than trying to do a lot (*General Medicine / Gastroenterology ward*)
- Vegetarian - not much choice (family bringing in food) (*Care of the Elderly ward*)

Elderly Ward);

- The attention shown by all the nursing staff, night and day, always smiling and good bedside manner (*Care of the Elderly Ward*).
- From my bed I could see very little that could be improved (*Intensive Care Unit*);

Complaints and the Help and Advice Service

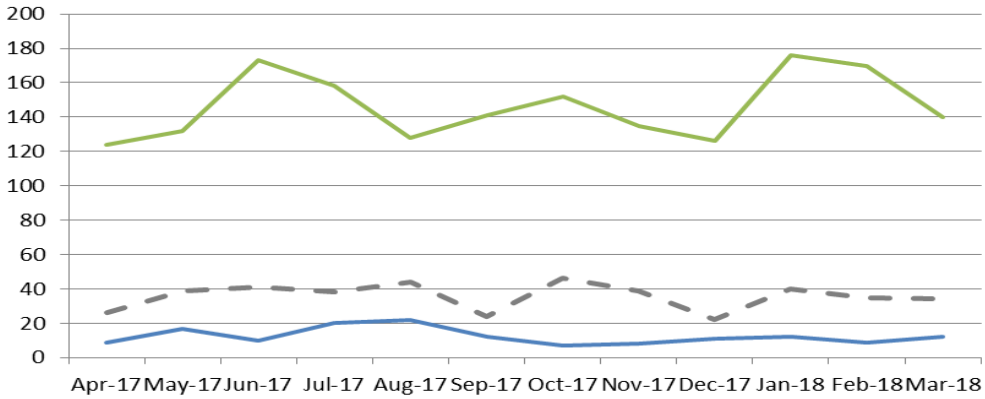
The Trust has an established complaints handling policy in line with the Department of Health's NHS and Social Care Complaints Regulations. This policy confirms that the Trust has a robust system in place to allow patients (or their nominated representative) the opportunity to have their concerns formally 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. and this enables the Trust to identify and monitor trends and themes, and ensure organisational action to reduce the risk of recurrence.

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 8.30 am and 4.30 pm and is 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.

The Trust received 427 formal complaints in 2017/18, an average of 36 per month. In 2016/17 there were 445 formal complaints received, an average of 37 per month, demonstrating a small 0.04% reduction this year.

The chart below shows a breakdown of feedback; compliments, formal and informal complaints. In 2017/18 there were 1,755 informal concerns received by the Help and Advice Service, which is a decrease from last year (1,961). There were 149 compliments recorded, which is less than last year, but it is recognised that many compliments received are not always recorded.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Compliments	9	17	10	20	22	12	7	8	11	12	9	12
Formal	26	39	41	38	44	24	46	39	22	40	35	34
Informal	124	132	173	158	128	141	152	135	126	176	170	140

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

The following examples highlights where we have made changes to our services as a results of patients raising concerns.

What Patients/Carers Said	Changes We Have Made
They waited more than 90 minutes in the Phoenix Unit before being seen	A notice is now displayed in the Unit advising patients who have been waiting more than 30 minutes to bring this to the attention of the receptionist
They did not understand the care of their child who had non-verbal autism	The Paediatric Consultant responsible for the care of the child has provided the mother with a letter detailing the plan of care for any future attendances at the hospital
Urine bottles weren't available at the bedside for immobile patients	Regular audits and routine monitoring is now in place to ensure that they are always available for patients, particularly for those who are immobile
There was some problems with catheterisation in the Day of Surgical Assessment Unit (DOSA)	Staff refresher training sessions for catheterisation has now been put in place to address any issues regarding knowledge, skills and competence
There was some delay in a young child having their Echocardiograph (heart test)	Referrals for this test will now be made from consultant to consultant to ensure the urgency of clinical need is appropriately communicated

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.

- Carers' week 12-18 June 2017
  Carers' Week annually raises awareness of caring and the challenges carers face and recognises the contribution they make to families and communities throughout the UK. Three in four carers say they do not feel that their caring role is understood or valued by their community. During Carers' Week, City Hospitals raised awareness of the role of carers with an event in the main concourse, with contributions from the Day of Surgery Admission Unit (DOSA) showcasing their work involving carers of patients with learning disabilities, the Dementia and Delirium Outreach Team (DDOT), Staff Care Coordinator who supports staff who are carers as well as external agencies who support carers. The event was so well received by both staff and visitors that it was repeated on Carers Rights Day on 24 November 2017.
- Carers Reference Group Meeting
  The Carers Reference Group meet quarterly to provide a representative patient and carers involvement forum for participating, reporting, reflecting on and improving patient and carers' experience in hospital. The Group Terms of Reference have been reviewed and an invitation extended to include more staff and carer members to the group.
- The Carers' Charter
  Information about the update to the Carers' Charter has already been included in the section on improving the experience of patients and their families with Dementia.

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 2018 in order to increase our team of volunteers. 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. Members of our volunteer team have been actively involved in the PLACE inspections 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 inspections was the fifth year of PLACE and once again there were a number of minor changes to the process.

The inspections took place at the Sunderland Royal Hospital and Sunderland Eye Infirmary between the 21 and 22 March 2017 and covered the following areas:

- Cleanliness;
- Condition and Appearance;
- Privacy Dignity and Wellbeing;
- Dementia Environment;
- Disability; and
- Food.

City Hospitals continues to value the contribution of patient representatives and this year saw a number of new patient representatives, including volunteers, Trust Governors and Healthwatch volunteers joining the inspection team. As a quality improvement process, PLACE focuses entirely on the care environment and does not interfere with clinical care provision or compromise patient confidentiality. It extends only to areas accessible to patients and the public (for example, wards, departments and common areas) and does not include staff areas, operating theatres, main kitchens or laboratories.

The results from PLACE were published on the 15 August 2017 and continue to show strong performance against national averages at both the Sunderland Royal Hospital and Sunderland Eye Infirmary sites. The dementia domain is the only area where one of the Trust sites (Sunderland Royal Hospital) was slightly below the national average. A summary of the results is show below by domain:

PLACE Inspection Scores 2017	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
National Average	98.38%	89.68%	83.68%	94.02%	76.71%	82.86%
Sunderland Royal Hospital	99.81%	95.83%	86.57%	94.83%	75.19%	83.86%
Sunderland Eye Infirmary	98.86%	99.33%	82.20%	93.23%	80.97%	84.98%

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.

Some members of the inspection team had been involved in previous inspections and the general feeling was that environmental standards across both sites had improved once again. There was an improvement in the Outpatients scores, a reflection of the developments that have taken place recently, most notably in Endoscopy, the Alexandra Unit (a multi-disciplinary specialist unit for patients with delirium and dementia) and the Phoenix Unit (our Chemotherapy Day Unit). There was an improvement in the dementia scoring from last year, mainly due to the introduction of large faced clocks, Ward Information boards, dementia-friendly decoration and handrails. Further Charitable Funds have been made available to roll this out across all Wards and Departments where dementia patients are likely to attend.

In terms of those areas requiring action, the Renal Unit was highlighted as requiring improvements across a number of domains. Refurbishment work is already underway as part of the Renal Water Plant replacement project, which should address and resolve many of the environmental issues.

The findings from the PLACE inspections have been shared with Divisional General Managers, Directorate Managers, Matrons and Ward and Departmental Managers. The report has also been discussed with the G4S Domestic Team and the Facilities team is 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 action plan will be measured for effectiveness against National Standards of Cleanliness and progress will be shared via the National Standards of Cleanliness Group with Matrons and Infection Control. Any food related issues will be addressed through the Nutritional Steering Group. All outcomes will also be discussed at the Strategic Infection Prevention and Control Group and Facilities Heads of Department meetings.

Part 3.2 Performance against key national priorities 2017/18

Performance against national measures

During 2017/18 the Trust has continued to achieve national operational and quality requirements 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). The Trust also maintained a low number of cases of hospital acquired healthcare infections.

Performance against targets such as waiting times for consultant-led treatment, cancer, diagnostic procedures and time in A&E are taken into consideration by NHS Improvement, the regulator of Trusts, as part of their regular assessment to determine any support required. NHS Improvement also review performance against other areas such as quality of care, finance and use of resources. Trusts are segmented into four categories based on the level of support required in order to meet required standards from 1 (maximum autonomy/no support) to 4 (special measures/mandated support). The Trust has remained in segment 2 during 2017/18 with some targeted support in place in order to sustainably achieve the A&E and cancer 62 day standards as well as improve the financial position of the Trust.

For some indicators the Trust was below the standard set for 2017/18. However, across a number of indicators there has been an improvement (or reduction dependent upon the specific indicator) from the previous year, and areas where performance was marginally below/above the standard. This includes waiting times for diagnostic tests, ambulance handover delays and mothers who smoke at the time of delivery.

Performance against key targets 2017/18

Indicator	Last Year 2016/17	Target 2017/18	2017/18	Variance	Year[1]
National Operational Standards					
Referral to Treatment waits % incomplete pathways waiting less than 18 weeks[2]	94.00%	92%	94.21%	2.21%	●
Diagnostic Test waiting times[2]	2.14%	1%	1.32%	0.32%	●
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	92.97%	95%	91.25%	-3.75%	●
All Cancer Two Week Wait	94.41%	93%	96.53%	3.53%	●
All Cancer 62 day urgent referral to treatment wait	83.10%	85%	83.62%	-1.38%	●
62 day wait for first treatment following referral from an NHS Cancer Screening Service	82.61%	90%	96.67%	6.67%	●
31 day standard for cancer diagnosis to first definitive treatment	98.48%	96%	98.32%	2.32%	●

31 day standard for subsequent cancer treatments - surgery	99.47%	94%	96.78%	2.78%	●
31 day standard for subsequent cancer treatments - anti cancer drug regimens	99.88%	98%	99.78%	1.78%	●
Cancelled operations not rescheduled within 28 days	34	0	58	58	●
Mixed sex accommodation breach	4	0	0	0	●
National Quality Requirements					
HCAI - MRSA Bacteraemia[3]	5	0	1	1	●
HCAI - Clostridium Difficile[3]	20	≤34	22	-12	●
Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	0	0	●
Ambulance Handover Delays 30-60 minutes	1349	0	1190	1190	●
Ambulance Handover Delays 60+ minutes	381	0	271	271	●
Trolley waits in A&E not longer than 12 hours	0	0	0	0	●
No urgent operation should be cancelled for a second time	0	0	0	0	●
VTE risk assessment for inpatient admissions	98.50%	95%	98.68%	3.68%	●
Duty of Candour	118	N/A	107	N/A	N/A
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	99.97%	99%	99.97%	0.97%	●
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS	99.61%	95%	99.53%	4.53%	●
Local Quality Requirements					
eReferral - % utilisation	73.12%	85%	67.78%	-17.22%	●
A&E left without being seen	1.94%	5%	1.88%	-3.12%	●
A&E time to initial assessment (median)	9 mins	9 mins	12 mins	3 mins	●
A&E time to treatment (median)	52 mins	60 mins	54 mins	-6 mins	●
Serious incidents - % reported on STEIS <2 working days	94.29%	100%	84.62%	-15.38%	●
Serious incidents - % 24 hour reports received for a never event	100.00%	100%	100.00%	0.00%	●
Serious incidents - % Initial reports received <72hrs	63.64%	100%	100.00%	0.00%	●
Serious incidents - % action plans <60 days of reporting on STEIS[4]	16.18%	100%	36.00%	-64.00%	●
Serious incidents - % lessons learned entered on STEIS for all completed	74.19%	100%	100.00%	0.00%	●
Serious incidents - % requests for information received <1 month of deferral	57.14%	85%	60.00%	-25.00%	●
Ambulance diverts and deflections from the Trust	66	N/A	8	N/A	N/A
Ambulance diverts and deflections to the Trust	97	N/A	38	N/A	N/A
Maternity – smoking at the time of delivery	17.23%	≤18%	18.04%	0.04%	●
Maternity – breastfeeding initiation	54.35%	58%	49.56%	-8.44%	●
Cancer waits - % waiting longer than 104 days with	0.00%	0%	0.00%	0.00%	●

no RCA					
Cancer waits - % waiting longer than 104 days with RCA & clinical harm review[5]	97.87%	100%	100.00%	0.00%	●

[1] Rated as amber if performance is close to target i.e. within 2 percentage points or 5 individual cases / minutes

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

[3] Cases apportioned to Acute Trust only. *C. diff* cases also exclude cases agreed at local appeals panels as not being genuine CDI or Trust apportioned cases

[4] Performance relates to only 25 cases throughout the year

[5] April to December 2017

Diagnostic test waiting times

The Trust was marginally above the target of less than 1% of patients waiting for a diagnostic test for more than 6 weeks. This was mainly due to an increase in demand for echocardiography as well as capacity issues which had arisen during 2016/17. Performance returned below the 1% standard in September 2017 and apart from one month has now remained under the target level.

Accident ad Emergency (A&E)

During 2017/18 the Trust has continued to receive an increasing number of patients through our A&E departments with a 6% increase compared to 2016/17. As a result we did not achieve the national standard of 95% of patients spending a maximum of 4 hours in the department despite relatively good performance during quarters 1 and 2 of the year. Performance was also better than the national average for all months of the year apart from January.

Our ability to achieve the standard was impacted by increased operational pressures over the winter period with increasing attendances, more patients requiring admission to a hospital bed and an increase in patients with Influenza. This has resulted in some delays in patients waiting in A&E for an inpatient bed. Despite this we saw a reduction in ambulance handover delays from 2016/17 with improvements made to processes and the environment in the new Emergency Department.

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. Delivery of the 4 hour standard remains a risk for the Trust as we move into 2018/19.

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. The Trust was marginally below this standard in 2017/18 however performance was consistently above the national average and the standard was achieved for all quarters apart from quarter 1 which is a significant achievement.

Work has been ongoing throughout the year to improve cancer pathways and ensure patients receive timely treatment. Investment has been made into Urology in particular to increase capacity and improve the pathway for patients. Whilst achievement of this standard remains a challenge due to complex pathways, the Trust is in an encouraging position as we go into 2018/19.

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.
- Internal indicators – these are agreed as part of our annual planning process and KPIs 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 Finance and Performance Committee, a formal subcommittee of the Board of Directors;
- Detailed monthly reports for divisional general managers, directorate managers and clinical directors;
- Performance and contract meetings with directorate managers and external meetings with commissioners.

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 2017 to March 2018;
- 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 2017 and March 2018;
- 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.

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, Durham Dales, Easington and Sedgefield, North Durham and South Tyneside 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 2017/18 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 2017/18 priorities and in the on-going delivery of the quality measures.

Throughout 2017/18 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 has conducted a programme of clinical quality assurance visits to the Trust in 2017/18. The purpose of these visits 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. A programme of joint CCG visits between Sunderland CCG and South Tyneside CCG across the South Tyneside and Sunderland Healthcare Group is being planned 2018/19.

There are a number of areas where the Trust has made quality improvements in 2017/18 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, particularly the 38.6% decrease in the rate per 1000 bed days. The CCGs acknowledge the plan for continuous improvement as a quality priority for 2018/19 and will continue to monitor the Trusts position on this through the Quality Review Group (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 continued commitment to Regional Mortality Group. The CCGs are assured by the mortality review processes implemented by the Trust, and this continues to be monitored by 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 2018/19 and look forward to receiving updates in respect of this priority at QRG.

The commissioners would like to congratulate the Trust on the organisational development work carried out to date and on their positive Staff Friends and Family Test results. We note that the number of staff completing the survey has decreased compared to the previous year and look forward to receiving an update at the QRG that details the Trust plans to improve response rates to continue to ensure meaningful results.

We would like to acknowledge and commend the Trust on their contribution to regional and national research projects, which is recognised by the number of short-listed entries and first prize for the collaborative project between South Tyneside and Sunderland Healthcare Group and the pathology department of Gateshead Health NHS Foundation Trust.

The CCGs would like to note the Trust's progress in implementing three out of the four priority standards for Seven Day Services, which is encouraging, and the CCG supports the inclusion of the implementation of these standards as one of the quality priorities for 2018/19.

The commissioners would like to highlight the work carried out to date to improve the completion, documentation and visibility of Do not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders and would support the inclusion of mandatory DNACPR training for staff to ensure full compliance with the Trust standard.

We would like to highlight the positive results of the process to improve fluid management, and acknowledge the Trust's findings that further work is required, so look forward to receiving updates at the QRG.

Whilst it is disappointing that the Trust has not been able to fully achieve all the Sepsis Commissioning for Quality and Innovation (CQUIN) indicators, the CCGs would like to acknowledge the work the Trust has undertaken such as the Trust wide event for World Sepsis Day, promotion and education on the Sepsis 6 Bundle, the innovative use of information technology as well as participation in regional work streams. We look forward to an improvement in the attainment of the 2018/19 Sepsis CQUIN indicators.

We would like to congratulate the Trust on again being below their trajectory for Clostridium Difficile following the appeals process agreed with Sunderland CCG. It is disappointing that for the fifth year, the Trust has not achieved the zero tolerance target for MRSA bacteraemia with 1 confirmed case recorded in 2017/18, however acknowledge that this is a reduction on the 5 cases reported 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 learning and improvements. The Joint Health Care Associated Infection Improvement (HCAI) group will continue its positive contribution to this agenda and remain sighted on the issues.

The CCGs wish to recognise and commend the work of the Trust on the focus on patient experience and the results of the national patient surveys. We would like to congratulate the Trust on the results of the 2017 Maternity Survey, with the Trust noted as the best performing Trust in the region for the care and attention women received after the birth of their babies. The Trust has highlighted their Quality Strategy which provides a framework for improvements in patient experience, and we look forward to seeing the results of this in subsequent Quality Reports.

The CCGs acknowledge the Trust's ongoing work in respect of Duty of Candour and look forward to further updates throughout 2018/19. The Trust continues to be a high performer in reporting incidents to the National Reporting & Learning System. The Trust reported a further 2 Never Events in 2017/18; 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. The CCGs 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 2018/19 and consider that these are appropriate areas to target for continued improvements, which align to the CCG's commissioning priorities. We recognise the value of all of the priorities identified and appreciate the continuation of targets from 2017/18. We look forward to sustained improvements in the reduction of Hospital Acquired Pressure Ulcers, reduction in patient falls with harm and improved documentation in respect of Do Not Attempt Cardio Pulmonary Resuscitation orders. We are pleased to see that for each priority, a dedicated group will have responsibility for driving forward the changes with a clear reporting structure.

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: 15 May 2018

Statement from Sunderland Scrutiny Committee

Sunderland City Council's Health and Wellbeing Scrutiny Committee are once again pleased to be afforded 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. The Health and Wellbeing Scrutiny Committee Members continue to have a constructive relationship with City Hospitals Sunderland NHS Foundation Trust while at the same time ensuring a critical friend challenge, voicing the concerns of the public and acknowledging good practice and improvements in service delivery.

The Health and Wellbeing Scrutiny Committee acknowledges the significant performance improvements against the 2017/18 priorities, in particular the reduction in the number of hospital developed pressure ulcers and the development of a trust-wide 'Learning from Deaths' policy. The Committee are also encouraged by the work that is being undertaken on the patient and staff experience. It is extremely important that both patients and staff are provided with suitable opportunities, and encouraged, to express their views about City Hospitals.

In looking at the priorities for quality improvement in 2018/19, the Health and Wellbeing Scrutiny Committee acknowledges the key aspects of patient safety, clinical effectiveness and the patient experience that national guidance instructs the Trust to focus on. The Committee recognises the importance of the work on the identification and treatment of sepsis, the reduction in the incidence of patient falls that result in severe harm and the improvement of medication management in order to reduce preventable patient harm.

The Health and Wellbeing Scrutiny Committee is also satisfied that the Trust continues to perform well against national CQUIN targets and that work is ongoing to improve those areas of performance that are identified as below the national standard. The Committee also acknowledges City Hospitals Care Quality Commission (CQC) ratings and in particular the work that has been done to address the 'Requires Improvement' judgement for Sunderland Royal Hospital. The Health and Wellbeing Scrutiny Committee would request that the outcome of the proposed CQC inspection in Spring 2018 is reported to the Committee at an appropriate juncture.

The Joint Health Scrutiny Committee established between Sunderland and South Tyneside Local Authorities continues to work with the Trust and partners on its ambitious programme of reform 'The Path to Excellence'. The Joint Health Scrutiny Committee will continue to represent and voice the concerns of the public throughout this programme.

Sunderland City Council's Scrutiny function values its relationship with the Trust and City Hospitals and will continue, through a variety of means, to challenge and engage with the Trust over key health issues that face the city. The Health and Wellbeing Scrutiny Committee are therefore satisfied in endorsing this quality report for 2017/18.

Date: 10 May 2018

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 2017/18 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 2017 to March 2018;
    - papers relating to quality reported to the board over the period April 2017 to March 2018;
    - feedback from commissioners dated 15 May 2018;
    - feedback from Overview and Scrutiny Committee dated 10 May 2018;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 10th May 2018;
    - the 2016 national patient survey dated 20th July 2017;
    - the 2017 national staff survey dated 6th March 2018;
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2018 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 2017/18. 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 & Lead /Trust Secretary
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.**