“Every staff member has been approachable, empathetic, has treated me with dignity and has made my stay comfortable.”
Welcome to our 2014/15 Quality Account which reviews our performance on safety and quality and sets out our safety and quality priorities for 2015/16.

Section Two sets out how we performed against a range of safety and quality indicators and describes the progress we made against the priorities we set ourselves for 2014/15.

What this shows is that the mortality rates across the hospitals are better than the national average, and our staff can be proud of the ongoing reduction in infection rates, with a year-on-year decrease in the number of cases of Clostridium difficile and Methicillin resistant Staphylococcus aureus (MRSA).

However, our success in these areas is balanced by the challenges we face in ensuring patients who arrive at our hospitals in an emergency are treated, admitted or discharged safely and quickly. Our performance against the four-hour Accident and Emergency standard has remained below the required level of 95% throughout the year.

We also struggled to meet the planned care waiting times standards in the second half of the year and many of our patients and staff experienced problems with our new Central Booking Hub, which we are now working to resolve.

This was reflected in the findings of the Care Quality Commission (CQC) inspection which took place in May 2014. The CQC found that patient flow was having an impact on care and patient experience in the Emergency Department (ED) and on the wards and also on the planning and support that people received when they were ready to leave hospital. They also found that the implementation of the centralised booking system had caused problems for patients and staff alike.

However, the CQC also found many good things including the care for patients with dementia in both the Royal Sussex County and Princess Royal Hospitals, where staff had been innovative and creative in order to provide a safe and stimulating environment for people. The critical care teams at the Royal Sussex and Princess Royal Hospitals were also found to be strong, committed and compassionate.

In September 2014 we introduced a new clinical structure, moving from four large divisions to 12 clinical directorates. These changes were designed to bring decision-making closer to staff and patients and improve patient safety and quality. While still work in progress, we are starting to see some of the benefits of these new arrangements.

Section Four of the Quality Account describes ‘Ten High Impact Programmes’ which we believe will help deliver improvements in the safety and quality of care in our hospitals and address the challenges I have described earlier. These programmes will also help us move towards the person-centred vision which we will set out this year in our Safety, Quality and Patient Experience Strategy, and which is described in this report. We have also identified, in discussion with our clinicians and partners, the three projects described in Section Four which will improve patient safety and the experience of patients.

To the best of my knowledge the information in this document is accurate.

Matthew Kershaw
Chief Executive
Our values and behaviours

Communication
...that’s respectful, personal, honest and helpful

Because it is the bedrock of effective teamwork and high quality patient care

Kindness and Understanding
...so that we feel supported and enabled to do our jobs

Because it is what patients need from us and what we need from each other

Fairness and Transparency
...in our decisions and actions

Because it builds trust and confidence in each other and for our patients

Working Together
...to get the best outcome for patients

Because patients expect seamless care and more effective team working improves clinical outcomes

Excellence
...always striving to be the best we can be

Because as professionals we should always try to do the best job we possibly can

Each value is underpinned by a set of behavioural do’s and don’ts and work is ongoing to embed these across the organisation
Brighton and Sussex University Hospitals NHS Trust provides District General Hospital services to our local populations in and around Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients from across Sussex and the South East of England.

In 2014-15 we saw more than:

- **43,900** Emergency (non-elective) admissions
- **35,500** Day case admissions
- **329,400** Outpatient attendances
- **12,200** Planned (elective) admissions
The Trust previously had four large clinical divisions, separated into a multitude of managerial groupings, and this structure was found to be unwieldy, lacking in clear lines of accountability, disconnected from the external agenda and lacking focus. A new clinical structure was introduced which is disease-based and reflects the way patients move across the Trust and interact with primary, community and secondary care. The make-up of the structure is outlined below:
Our approach to quality

The Trust’s approach to quality is centred on our patients, through a number of questions about patient safety and patient experience. The vision of the strategy is to move to a person-centred view of safety and quality with a particular focus on kindness and compassion as the driver for the delivery of the high quality services desired by the population we serve.

How can I be sure that the care I receive will not harm me?

In order to minimise the risk of harm, the care patients receive should:
- be delivered by people that pre-empt error wherever possible
- be delivered by people that are proactive about recognising error and risk
- come from people that are capable of learning from mistakes made by themselves as well as other healthcare professionals

How can I be sure that I will receive the best possible care?

In order to provide patients with the best possible care it should:
- be delivered according to the best current evidence
- be measured against appropriate outcomes for the patient
- be delivered in accordance with relevant national targets with regard to waiting times
- be delivered by the most appropriate, best trained people in adequate numbers

How can I be sure that feedback on experiences will be acted upon?

In order to ensure that feedback on the care of patients is used effectively we will:
- actively seek feedback on the care that we provide
- strive to adjust care in the light of the feedback received
- act promptly to address concerns when patients raise them
- be open and honest about the reasons if the care falls below the standard expected

How can I be sure that I will be involved in making decisions that affect me?

In order to ensure patients are fully involved in their care it should:
- place the patient at the centre of any decisions
- be delivered by staff who recognise and value the patient as an individual
- ensure that communication with the patient is clear, effective and timely
In order to ensure patients are treated fairly and do not suffer discrimination we will ensure that:

• the services we deliver reflect the problems faced by patients and their community
• information is provided in a form that patients can understand
• patients are able to access and navigate our buildings and premises

In order to ensure kindness and compassion the care patients receive should:

• be delivered by a group of individuals who share a common set of values and behaviours with kindness and compassion at their core
• actively seek the needs, wishes and fears of the patient as well as those of the patient’s family and carers
• be individual to you and make you feel valued

How can I be sure that I will be treated fairly, as an individual and part of my community?

How can I be sure that I will be treated with kindness and compassion?

Care should be delivered by a group of individuals who share a common set of values and behaviours with kindness and compassion at their core.
I have had amazing care. Everyone has shown so much professionalism and compassion.”
Review of quality performance

This section of the report describes the progress we have made on the priorities we agreed last year. We are taking forward three of these projects as our safety and quality priorities for 2015/16: improving care for frailty patients; improving care for the deteriorating patient - sepsis; and improving care for the deteriorating patient - Acute Kidney Injury (AKI). These three projects also form part of the Safety Pledges in our ‘Towards a safer hospital’ programme. Our pledges are set out on page 42.

Reducing avoidable falls

Why? Inpatient falls in hospital are a ubiquitous problem throughout healthcare and a significant source of increased length of stay, excess morbidity and avoidable mortality every year within the Trust. When this project was initiated in 2009 over 1,500 clinical incident reports per annum were submitted detailing patient falls. Over 200,000 falls are reported to the National Reporting and Learning System annually making it a significant problem, not only locally, but on a national level. Although not all falls can be prevented we have learnt that a significant number can be avoided.

Targets set for this financial year (April 2014/March 2015): Partially Achieved
The target was to reduce the falls rate by a further 10%, which would mean bringing the rate down to 3.13 falls per 1000 bed stays. The Trusts strategic approach to reducing falls changed in 2014-15. In line with national guidance the focus shifted away from quick learns from each falls to in-depth analysis of falls resulting in harm. In addition, the last quarter of 2014-15 was very challenging and consequently the gains made between April and December were lost. Overall the rate was down 1.4% on last year at 3.43 falls per 1000 bed stay days.

Improvements delivered in this financial year (April 2014/March 2015): In collaboration with Brighton and Hove CCG a template for the investigation of serious falls has been developed and will be adopted by other Trusts in the South East. A number of research bids have been developed to explore the methodology developed that was employed to reduce the Trust rate of falls by 45%. These bids have been developed in collaboration with the University of Southern Denmark, Kingston University and faculty from the Doctor of Management programme at the University of Hertfordshire. The Falls Initiative was also selected as one of the three finalists for the Patient Safety Collaborative Award at the Kent Surrey Sussex Academic Health Science Network ceremony.

Future goals for the next financial year (2015/2016): The goal for 2015/16 will be an overall 7% reduction in the falls rate.

Reducing hospital acquired infection

Why? Infection prevention and control is vital in ensuring patient safety, preventing harm, delivering good outcomes, maintaining the Trust’s reputation and the public’s confidence. Over recent years the Trust has made great reductions in the rates of hospital acquired infections and this work will continue over the coming years.

Targets set for this financial year (April 2014/March 2015): Achieved
Infection control targets are set nationally. The reduction target goal for 2014/15 is zero avoidable MRSA bacteraemias and no more than 50 Trust-acquired cases of Clostridium difficile (Note: The nationally set target for the number of hospital-acquired Clostridium difficile cases is higher than the target that was set in 2013/14).

Improvements delivered in this financial year (April 2014/March 2015): We had 45 Trust-acquired cases of Clostridium difficile. We have also had two unavoidable MRSA blood stream infections and two contaminated MRSA blood cultures (where MRSA was isolated in the sample but there was no evidence of infection and the patient was not treated).

Future goals for the next financial year (2015/2016): The reduction target for 2015/16 is zero avoidable MRSA bacteraemias and no more than 46 Trust-acquired cases of Clostridium difficile.

There were 45 cases of Clostridium difficile against a target of 50.
Section 02

Patient transfer

Why? At any point where there is a hand-over of care between individuals or teams there is a risk of information being lost which could negatively affect patient care. The timing of patient transfers is also important in terms of safety and patient experience along with ensuring appropriate escort.

Targets set for this financial year (April 2014/March 2015): Partially Achieved
1) To undertake a series of case note reviews for patients with multiple transfers.
2) To develop a package of care to improve the quality of transfers within the hospital. As part of this package a range of quality metrics will be identified.
3) To identify themes and develop strategies for reducing unnecessary transfers.
4) To implement a ‘safer transfer’ package of care.

Improvements delivered in this financial year (April 2014/March 2015): During 2014/15 we have developed a multidisciplinary working group and have carried out several process mapping sessions in order to review the process, practical and personal issues surrounding the undertaking of a safe patient transfer. We have undertaken a series of notes reviews and data analysis in order to identify trends, themes and complications relating to multiple transfers. In addition to this the Lead Nurse for Safety and Quality has been working closely with the porters on an initiative that ensures that when any patient is transferred that they do not leave the area without their belongings.

Future goals for the next financial year (2015/2016): We plan to extend the project over the next two years using the intelligence gathered in 14/15 to develop a care package for a safe patient transfer. In addition we are looking to obtain funding for and introduce a transfer team to support staff to facilitate a safe and appropriate transfer and for education and simulation.

Reducing harm from medication (medication reconciliation)

Why? The National Institute for Health and Care Excellence (NICE) have evidenced that medication errors occur most commonly during transfers between care settings and particularly at the time of admission. NICE cite two reviews which reported unintentional variances of 30-70% between the medications patients were taking before admission and their prescriptions on admission. The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission.

Targets set for this financial year (April 2014/March 2015): Partially Achieved
To ensure that 90% of patients have medication reconciliation within 24 hours of admission to hospital.

Improvements delivered in this financial year (April 2014/March 2015): In this financial year medication reconciliation rates have risen from 71% up to 88%. Monthly data collection to ensure that rates are monitored and constantly reviewed for improvement has now been embedded in to practise. Although the target of 90% has not yet been reached the monthly audit shows a steady increase in medicines reconciliation rates across the Trust. A large factor that affects the medicines reconciliation rates still needs to be addressed and this is the need to provide a full seven day pharmacy service at ward level. This has so far been rolled out to specialist medicine wards and the acute services.

Future goals for the next financial year (2015/2016): To keep the target of 90% for all patients to have a medicines reconciliation within 24 hours of admission as a Trust priority for 2015/16.

Mortality

Why? Mortality data is a key indicator of the quality and safety of the services provided by a hospital.

Targets set for this financial year (April 2014/March 2015): Partially Achieved
To implement a standard process for mortality review across the Trust.

Improvements delivered in this financial year (April 2014/March 2015): In collaboration with the Trust’s IT department, a database for the clinical review of every patient who dies in the Trust has been developed. This database will provide a systematic way for clinicians to review the care given to the patient during their final admission. The database is currently being piloted.

Future goals for the next financial year (2015/2016): The initiative will now be taken forward and monitored by the Trust’s Mortality Group.
**Enhanced recovery**

Why? The Enhanced Recovery Programme (ERP) is about improving patient outcomes and speeding up a patient’s recovery after surgery. It results in benefits to both patients and staff. The programme focuses on making sure that patients are active participants in their own recovery process. It also aims to ensure that patients always receive evidence based care at the right time, maximising the benefits of a speedy recovery and return to normal day-to-day activities.

Targets set for this financial year (April 2014/March 2015): ** Achieved  
To continue to improve performance by ensuring all patients are measured within best practice and meet the targets outlined for Kent, Surrey and Sussex in-line with the local CQUIN (Commissioning for Quality and Innovation) agreement. To continue to improve patient information and awareness through the development of an external facing webpage and short film on what to expect during their recovery period after surgery.

**The Enhanced Recovery Programme (EPR) is helping to speed up a patient’s recovery after surgery**

Improvements delivered in this financial year (April 2014/March 2015): During 2014/15 the Trust has continued to improve on the best practice improvement target set by the regional Enhancing Quality and Recovery (EQ&R) team across Gynaecology, Colorectal and Hip and Knee.

Although we are not at the end of the improvement period we are already achieving above the target set and in recent months have achieved 100% across all aspects of care. In addition to the existing work we are also moving the Enhanced Recovery principles into other areas, for example Emergency Laparotomy and Caesarean Section.

Future goals for the next financial year (2015/2016): Continue to develop Enhanced Recovery into other areas of surgery to improve patient outcomes and experience and continue to achieve the 15/16 improvement target set by the regional team and engage in collaborative events to share best practice.

**Quality reviews**

Why? Quality reviews, also known as ‘Sit and See’, are used as a form of peer review where multidisciplinary teams visit areas using the framework around quality of care, kindness and compassion. This involves talking to patients and staff about their experiences in the hospital and observing the delivery of care. Feedback will be given to teams on areas of good practice and areas for improvement. It will also be used to share best practice across the organisation.

Targets set for this financial year (April 2014/March 2015): **Achieved  
A programme of multidisciplinary quality reviews were undertaken on a monthly basis.

**Improvements delivered in this financial year (April 2014/March 2015):** Themes identified with the quality visits have been shared with the lead nurses and ward managers and have led to numerous workstreams, such as reducing ‘noise at night’ in the hospital.

**Future goals for the next financial year (2015/2016):** The quality visit framework will be reviewed to reflect the Fundamental Standards of Care. The directorates will be encouraged to participate in the monthly programme and use the framework as part of their quality assurance processes within their teams. It will help to inform the directorate’s future quality and safety programme.
Section 02

Improving care for frailty patients

Why? The Care of frail, usually elderly patients is a core part of the Trust’s Clinical Strategy. Recent national reports including the Francis Inquiry have all been critical of the care delivered to our frail and elderly patients. There is increasing evidence that a move towards shifting services closer to the front door of the hospital and outward facing into the community provides better outcomes for frail and elderly patients. This initiative is aimed at developing a whole system approach to care for frail patients.

Targets set for this financial year (April 2014/March 2015): Partially Achieved

1) Define frailty in the Emergency Department in order to identify patients that would be considered for frailty-specific care and receive comprehensive geriatric assessment.
2) Ensure all patients who meet the criteria for the frailty pathway are entered into the FRAILsafe tool.
3) Develop the case for a fully funded ‘Frailty Team’
4) Develop robust measurement around frailty.

Improvements delivered in this financial year (April 2014/March 2015): In 2014/15 we have developed a multidisciplinary cross-sector working group to successfully support the development and implementation of frailty-specific care. We are now using the FRAILsafe tool and have a multidisciplinary frailty team at the front door to identify and signpost patients with complex frailty needs through acute care and safely back out into the community.

Future goals for the next financial year (2015/2016):
In 15/16 – 16/17 we plan to continue the development of the service and are currently working on the paperwork to support frailty care which will further streamline and support all elements of the patient’s journey and overall care delivery. In addition the care will provide a robust source of data for identification and measurement.

Improving care for the deteriorating patient - Sepsis

Why? Sepsis is a common and potentially life threatening condition where the body’s immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. Problems in achieving consistent recognition and rapid treatment are thought to contribute to the number of preventable deaths from sepsis. It is estimated that the reliable delivery of basic elements of sepsis care could save up to 11,000 lives a year and £150 million annually.

Future goals for the next financial year (2015/2016):
To improve the early identification and treatment of patients who are at risk of sepsis on arrival to the hospital via the Emergency Department or by direct emergency admission to another unit e.g. Medical Assessment Unit or an acute ward by developing a process to;

• Screen for risk of sepsis
• Perform tests to confirm diagnosis
• Initiating intravenous antibiotics within one hour of presentation

Improving care for the deteriorating patient - Acute Kidney Injury (AKI)

Why? AKI is a sudden reduction in kidney function. It is not a physical injury to the kidney and usually occurs without symptoms. In England over half a million people sustain AKI every year with it affecting 5-15% of all hospital admissions. AKI enhances the severity of underlying illness, increasing the risk of death. Mortality rates of hospitalised patients with AKI are at least 20-33% and it is responsible for 40,000 excess deaths every year. As well as being common, AKI is harmful and often preventable, thus representing a major safety challenge for healthcare.

Future goals for the next financial year (2015/2016):
To improve the follow up and recovery for individuals who have sustained an AKI, reducing the risks of readmission, re-establishing medication for other long term conditions and improving follow up by developing a process for:

• Early identification of patients who are at risk of developing an AKI (using pathology systems)
• Alerting clinicians that their patient has sustained an AKI (using pathology reporting systems)
• Improving medication reviews
• Improving the information communicated to primary care relating to ongoing management after discharge
Improving the prevention of pressure damage

Why? There is clear evidence that pressure ulcers have multiple negative effects on a patient’s well-being. Pain, discomfort, depression, social isolation, prolonged hospital stays, increased morbidity and mortality risks are also well documented.

Targets set for this financial year (April 2014/March 2015): Not Achieved
The goal for 2014/15 was a 10% reduction in grade 2 pressure damage and no avoidable grade 3/4 pressure damage. Unfortunately for the first time in five years pressure damage rates have gone up. Overall there were 0.54 pressure damages per 1,000 bed stay days, which is an increase of 14.4%.

Communicating and learning from patients: Patients’ Voice

Why? The views of patients are an important measure in assessing the quality of care provided by staff. The Trust’s Patients’ Voice Survey and the National Patient Satisfaction Surveys (A&E, Inpatients and Cancer) are pivotal in understanding what patients feel about the services we provide. In addition we seek regular and real time feedback from patients and their representatives at the monthly Patient Experience Panel. This gives us the opportunity to obtain our patients’ views on the services we provide and also invites their input into service developments and improvements. For inpatients the Patients’ Voice survey has been adapted to incorporate the national Friends and Family Test (FFT). The FFT question of whether you (the patient) would recommend this hospital to a relative or friend is also asked in A&E and will be extended to outpatients during 2014-15. Our Complaints and Patient Advice and Liaison Service (PALS) teams work closely together to identify emerging themes from the informal and formal concerns received. The teams work closely with the specialties to ensure that lessons are quickly learnt from any reported poor patient experience.

Targets set for this financial year (April 2014/March 2015): Partially Achieved
1) To meet the national response rate targets for A&E, inpatients and outpatients.
2) To improve on this year’s inpatient score of 65 for Friends and Family Test and to increase the A&E score from 31.
3) To produce patient posters every two months with feedback on what we are doing with the comments made by patients.
4) Clinical staff engagement with complaints to be linked to performance management.
5) Develop a systematic approach to capturing learning from complaints.
6) Devise a fair and systematic approach to selecting patient stories to ensure they are representative of complaints received.
7) Action plans arising from national patient surveys to be reported and monitored by the Patient Experience Panel.

Improvements delivered in this financial year (April 2014/March 2015):
1) Achieved: 8,756 inpatient questionnaires were returned this year, which is a response rate of 27%.
Not achieved: For A&E 8,445 friends and family surveys were completed with a response rate of 9.2%.
2) The scoring system for Friends and Family Test was changed during the year.
Not achieved: Inpatient – the proportion of patients who wouldn’t recommend their ward increased marginally during this financial year from 1.70% to 1.73%. This figure of 1.73% is in line with the national average.
Achieved: A&E - the proportion of patients who wouldn’t recommend their A&E department has decreased this financial year from 10.2% to 9.2%. This is higher than the national average which was 6% in February 2015.
3) Achieved: Every ward has an A3 poster outside its entrance giving feedback on the Patients’ Voice survey.
Future goals for the next financial year (2015/2016):
To ensure the Trust’s FFT scores are better than the national average

Improving the prevention of pressure damage

The last quarter of 2014-15 was very challenging, consequently the gains made between April and December were not maintained.

Improvements delivered in this financial year (April 2014/March 2015): We have worked very closely with the CCGs on improving the investigation process of how pressure ulcers develop. We have also introduced new pressure relieving services to ensure that the highest risk patients are given the best pressure relief available in the UK.

Future goals for the next financial year (2015/2016): At the end of December 2014 the rate per 1,000 bed stay days was 0.45. The goal for 2015/16 is to bring it back to 0.45.
Section 02

Towards a more engaged workforce

Why? Anyone who has ever worked in any organisation will know that the people doing the job on the frontline day in, day out are the ones who really know what happens, what is done well, and what can be done better. Members of staff are often put off from making any improvements simply because they don’t know how to make the change, or don’t believe they will be listened to by the people at the top. In October 2012, the Innovation Forum (IF) was launched as a means of encouraging and enabling grassroots innovation. IF is a platform where anyone and everyone working at the Trust can voice their own ideas on the changes and improvements they see necessary. IF is set up to facilitate access to the right people, networks, and resources. Through IF, staff members are able to retain responsibility and ownership of their ideas and take the lead on their own innovative projects.

Targets set for this financial year (April 2014/March 2015): Achieved
Four successful Innovation Forums were run during the year and the CCGs are keen to adopt the model and run joint Innovation Forums between the Trust and the community.

Improvements delivered in this financial year (April 2014/March 2015):

- Recruitment of a multidisciplinary committee, including a senior dietician, physiotherapist and pharmacist in order to encourage wider participation.
- A nurse-only event organised after the upcoming Trust Nursing Conference, to encourage more ideas from nursing staff.

Future goals for the next financial year (2015/2016):
We hope to engage more of the nursing workforce in the Trust, as well as Healthcare Assistants and Porters, to have more ideas from these groups presented at the Forum. Improve attendance at events.

Enhancing Quality

Why? Enhancing Quality (EQ) is a clinician-led quality improvement programme launched in January 2010 across Kent, Surrey and Sussex encompassing 10 acute Trusts, six community providers and three mental health Trusts. Enhancing Quality aims to improve patient outcomes and reduce variation in care.

Targets set for this financial year (April 2014/March 2015): Partially Achieved
To continue to improve performance against targets by ensuring that all patients get measured against best practice and meet the targets outlined for Kent, Surrey and Sussex in line with the local CQUIN (Commissioning for Quality and Innovation) agreement.

Improvements delivered in this financial year (April 2014/March 2015): We have continued to engage in collaborative learning events and the sharing of best practice. In 2014/15 the pneumonia care pathway was developed and now has enhanced measures for performance.

The target in 14/15 was to maintain the data completeness target, which has been achieved to allow target setting for 15/16. We have continued to struggle with meeting the Heart Failure performance measures in 14/15 due to wider service issues. These have therefore been the focus of this year’s work with the EQ measures being the tip of the iceberg. We have redesigned the service with our colleagues from primary care and have undertaken a whole system review. A business case is being prepared to support the delivery of the service and has been identified as a priority in business planning for 2015/16.

Future goals for the next financial year (2015/2016):
Continue to take part in collaborative learning events and the sharing of best practice within Kent, Surrey and Sussex. Continue to develop the Heart Failure service and to deliver the improvements required to meet the targets set for pneumonia.
Towards a safer hospital

Why? Frontline clinical staff have identified areas for improvement during their day-to-day work that will make a real impact to patients by ensuring safe care. The projects have been developed by frontline clinical staff and supervised by clinicians with expertise in quality improvement and ‘human factors’. Projects included in this are: towards a safer ward (ward round checklist), towards a safer transfer, towards a safer handover, towards a safer operating theatre, towards a safer emergency department.

Targets set for this financial year (April 2014/March 2015):
1) Reduction in length of stay
2) Reduction in medical emergency and cardiac arrest calls
3) Improved patient experience measured by Friends and Family Test scores
4) Development of a data visualisation tool to display complex information in a meaningful format
5) Reducing the number of transfers per patient

Improvements delivered in this financial year (April 2014/March 2015):
1) Awaiting Healthcare Evaluation Data
2) Insufficient data to draw a conclusion
3) Not achieved: The proportion of inpatients who would not recommend their ward (Friends and Family score) increased marginally this financial year from 1.84% to 1.86%.
4) Achieved: The data visualisation tool has been developed in collaboration with the Quality Observatory and is currently being evaluated.

Future goals for the next financial year (2015/2016):
The Towards a Safer Hospital Programme is being reviewed. The data visualisation tool will continue to be developed and reviewed by the Safety and Quality Committee.
Section 02

Values and Behaviours

Why? The Values and Behaviours programme was launched in 2013 as part of Foundations for Success. The programme aims to create an organisational culture and environment where staff and managers are skilled, resilient and feel supported, engaged and empowered to provide high quality and safe care/services.

Targets set for this financial year (April 2014/March 2015): Achieved
Over 700 staff joined focus groups to describe the workplace behaviours that enable them to provide the best and safest care/service. Led by a staff sounding board, this work was distilled into a behavioural blueprint, underpinned by a philosophy of staff empowerment and accountability.

The Behavioural Blueprint:
• Defines (in 50 simple ‘do’s and don’ts’) the behaviours we expect of each other to support best and safest care;
• Provides a framework for staff recruitment and selection (‘values-based recruitment’), aligned with the NHS Constitution;
• Provides a ‘touchstone’ for ensuring that the Trust’s systems and processes are aligned with these priorities.

The role of the Values and Behaviours programme has been to change the organisational culture by embedding the blueprint across the range of the Trust’s activities. In 2014/15 this has focused on three areas: (i) developing individuals and teams, (ii) aligning our people processes; and (iii) engaging for improvement.

Improvements delivered in this financial year (April 2014/March 2015): Developing Individuals and Teams
• Developed and published the Behavioural Blueprint through widespread, bottom-up staff engagement.
• Completed ‘Leading the Way’ leadership development programme (five one-day modules, each aligned with one of the behaviours; five follow-up Action Learning Sets) for 67 most senior staff.
• Published ‘bringing the behaviours to life’ toolkit to help frontline teams with their own team development, supported by a part-time Team Coach (from March 2015).

Aligning our People Processes
• Reflected the Behavioural Blueprint in recruitment/selection processes, and began planning to extend Values-based Recruitment to all staff in 2015/16.

Engaging for Improvement
• Recruited 127 volunteer, frontline Values and Behaviours Champions, to publicise and promote the Behavioural Blueprint in their teams - and provide feedback to the project.
• Developed a Staff Engagement and Communications Plan, including running regular ‘drop in’ open staff Values and Behaviours sessions on each site to provide staff with a channel to discuss ideas and concerns, and publishing a new monthly Talkback magazine.

A behavioural blueprint was produced with a philosophy of staff accountability and empowerment
“The nursing staff were so lovely, caring and professional at all times.”
Statutory declarations

The information in this section is mandatory text that all NHS Trusts must include in their Quality Account.

Review of services

During 2014/15 the Trust provided acute and specialised services to NHS patients through our contracts with our commissioners, with £460.8m of our income coming from Clinical Commissioning Groups and NHS England for patient care activity. The income generated by the NHS services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of NHS services by the Trust. Our clinical services moved from four Divisions to 12 Clinical Directorates in September 2014. Each of those Clinical Directorates and the specialties within them reviews the data available on the quality of care in their services. The services provided by each of the clinical directorates can be found at http://www.bsuh.nhs.uk/about-us/whos-who-clinical-directorates/. This is overseen by our Executive Safety and Quality Committee and to support this we implemented a Safety and Quality dashboard for each of the Clinical Directorates containing standard information on patient safety, clinical effectiveness and patient experience.

Performance against 2014-15 core set of indicators

The information on the data sources is available via https://indicators.ic.nhs.uk/webview/

Summary Hospital-Level Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

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<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
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<td>‘As expected’ (0.7547)</td>
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</tbody>
</table>

A SHMI score is calculated based on all hospital deaths and those who die within 30 days of a hospital admission. A SHMI score of 100 indicates there is no difference between the hospital’s mortality rate and the national average rate. If the score is greater than 100 this indicates that more patients than expected died. The SHMI score of 94.2 indicates that the Trust had 5.8% fewer deaths than expected.
Patient safety incidents and the percentage that resulted in severe harm or death

The number and, where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death:

(i) rate of patient safety incidents reported (per 100 admissions); (ii) rate of incidents that resulted in severe harm or death (per 100 admissions); (iii) number of incidents resulting severe harm or death.

Patients admitted to hospital who were risk assessed for venous thromboembolism

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period aged: (i) 0 to 15; and (ii) 16 or over

Patients readmitted to a hospital within 28 days of being discharged

The percentage of patients readmitted to a hospital within 28 days of discharge during the reporting period aged: (i) 0 to 15; and (ii) 16 or over

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves for the following procedures: (i) groin hernia surgery; (ii) varicose vein surgery; (iii) hip replacement surgery; (iv) knee replacement surgery

Responsiveness to the personal needs of patients

The Trust’s score with regard to its responsiveness to the personal needs of its patients during the reporting period.

The Trust considers this data as described because it has been taken from a national data set and improved participation rates during the year have resulted in a larger pool of data from which the scores are calculated. The Trust’s patient reported outcomes for varicose vein surgery are among the highest in England. However, the outcomes for hip and knee replacement surgery are worse than the national average and this is an area we need to improve in 2015/16 by analysing the data further and encouraging more patient responses.

The Trust considers that this data is as described because it is produced by the Picker Institute in accordance with strict criteria. An action plan that addresses the issues raised in the National Patient Survey has been developed and has been overseen by the Trust’s Patient Experience Panel.

The Trust considers this data as described because it is routinely scrutinised at the monthly Executive Safety and Quality Committee.

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) 0.080</td>
<td>0.085</td>
<td>0.125</td>
<td>0.062</td>
</tr>
<tr>
<td>(ii) 0.143</td>
<td>0.093</td>
<td>0.143</td>
<td>0.023</td>
</tr>
<tr>
<td>(iii) 0.401</td>
<td>0.436</td>
<td>0.483</td>
<td>0.342</td>
</tr>
<tr>
<td>(iv) 0.286</td>
<td>0.323</td>
<td>0.335</td>
<td>0.236</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) 12.08</td>
<td>8.76</td>
<td>5.86</td>
<td>12.5</td>
</tr>
<tr>
<td>(ii) 0.026</td>
<td>11.86</td>
<td>10.64</td>
<td>13.55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>96.12%</td>
<td>95.89%</td>
<td>99.87%</td>
<td>81.19%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.3</td>
<td>68.7</td>
<td>77.3</td>
<td>58.8</td>
</tr>
</tbody>
</table>
People and wellbeing strategy 2015-2020

The Trust Board approved a new People and Wellbeing Strategy in June 2015 with the ambition for the Trust ‘to be a great place to work and care for our patients’.

The strategy has a strong focus on improving staff engagement and the benefits this brings for patients.

### Staff who would recommend the Trust to their family or friends

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>69.65%</td>
<td>76.52%</td>
<td>94.62%</td>
<td>52.40%</td>
</tr>
</tbody>
</table>

The Trust considers this data as described because we have developed a systematic approach to the collection of the Friends and Family Test scores through our internal patient survey ‘Patients’ Voice’.

### Patients who would recommend the Trust to their family or friends

The Trust’s score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care in: (i) A&E; (ii) Inpatient areas; (iii) Antenatal care; (iv) Birth; (v) Postnatal ward; (vi) Postnatal Community Care.

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) 77.7%</td>
<td>86.8%</td>
<td>98.8%</td>
<td>67.1%</td>
</tr>
<tr>
<td>(ii) 92.7%</td>
<td>94.2%</td>
<td>99.6%</td>
<td>78.5%</td>
</tr>
</tbody>
</table>

The Trust considers this data as described because we have developed a systematic approach to the collection of the Friends and Family Test scores through our internal patient survey ‘Patients’ Voice’.

### Section 03

70% of staff would recommend the Trust
**Rate of C. difficile infection**

The rate per 100,000 bed days of Trust-acquired cases of C. difficile infection that have occurred within the Trust amongst patients aged two or over during the reporting period.

<table>
<thead>
<tr>
<th>BSUH rate</th>
<th>National average</th>
<th>Best performing teaching hospital</th>
<th>Worst performing teaching hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.0</td>
<td>14.7</td>
<td>1.6</td>
<td>37.1</td>
</tr>
</tbody>
</table>

The Trust considers this data is as described because every case is scrutinised weekly by the Trust’s Infection Prevention and Control Action Group and reported externally. While the Trust’s rate is higher than the national average, there has been a year-on-year reduction.
Participation in clinical audits

The national clinical audits that the Trust participated in, and for which data collection was completed during 2014/15, are listed in the following pages. During the year the Trust participated in 33 of the 35 national clinical audits (97%) in which it was eligible to participate. Where the Trust did not participate in a national clinical audit, the reasons are also described. This includes, for example, the National Cardiac Arrest Audit (NCAA) where the national audit is less comprehensive than the local audit we have had in place for a number of years. The reports of the national clinical audits detailed below were reviewed by the provider in 2014/15 and the Trust intends to take the actions described in this section of the report to improve the quality of healthcare provided.

Adult Community Acquired Pneumonia
Category: Acute
Eligible: Yes
Participating: Yes
Percentage of cases submitted: Not applicable - data collection ongoing
Actions to improve: The Trust is participating in data collection which is currently underway. The report for this audit is scheduled for July 2015.

Case Mix Programme (CMP)
Category: Acute
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: Substantial changes have been made to now allow both Princess Royal Hospital and Royal Sussex County Hospital to participate fully. When Hurstwood Park Neurosciences join the Royal Sussex County Hospital site, they too will participate. It is anticipated this will happen during 2015/16.

National Joint Registry
Category: Acute
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: Changes introduced two years ago (changing the implants used; and encouraging superspecialisation of surgeons) have facilitated a sustained improvement on revision rates for hips and knees.

National Emergency Laparotomy Audit (NELA)
Category: Acute
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: This is an ongoing audit and data continues to be collected and submitted on all applicable cases. Although the national report is not due until July 2015, the Trust has undertaken local analysis on initial data collected, which has enabled us to review standards of care and identify areas for improvement. Ongoing actions have taken place to raise the awareness of the pathway, including the introduction of prompt cards and pocket guides and the sharing of information at governance meetings.

Non-invasive Ventilation - adults
Category: Acute
Eligible: Yes
Participating: Not applicable
Percentage of cases submitted: Not applicable
Actions to improve: Originally scheduled for Feb/March 2015, the British Thoracic Society has now informed us that this will not happen in the 2015/16 audit cycle.

Pleural Procedures
Category: Acute
Eligible: Yes
Participating: Yes
Percentage of cases submitted: Not applicable - data collection
Actions to improve: June/July 2014 audit showed massive improvement in quality indicators since previous rounds after the introduction of the pleural pathway and intervention clinic. The Trust will maintain the current service and consider application to fund an ultrasound machine for respiratory wards.

Major Trauma: The Trauma Audit and Research Network (TARN)
Category: Acute
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: Cases are reviewed bi-monthly at the morbidity and mortality meetings. Clinical team reviews are also undertaken and the service is scrutinised at local level via the Trauma Committee and at regional level via the Operative Delivery Network. In addition, the Trust is reviewed annually by an external body, Peer Review Team.
National Comparative Audit of Blood Transfusion programme

Category: Blood and Transplant
Eligible: Yes
Participating: Yes
Percentage of cases submitted: Not applicable - data collection
Actions to improve: The Audit of Patient Blood Management in Scheduled Surgery is currently ongoing.

Bowel cancer (NBOCAP)

Category: Cancer
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: Update not currently available. However, the Trust participates annually in this national audit.

Lung cancer (NLCA)

Category: Cancer
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The reporting of data has changed this year which makes reviewing the local data submitted very difficult. However, the actions being taken are: (1) Review of the treatment pathway for non-surgically radically treatable early stage lung cancer; (2) Development of a treatment pathway for thymoma across Sussex; (3) Joint work with Mid Sussex and Brighton and Hove Clinical Commissioning Groups (CCGs) to review the pathway to diagnosis

Oesophago-gastric cancer (NAOGC)

Category: Cancer
Eligible: Yes
Participating: Yes
Percentage of cases submitted: <100% (a technical IT interface issue has prevented full upload)
Actions to improve: The Trust is a specialist Oesophago-gastric cancer centre and tracks patients diagnosed in neighbouring Trusts. A patient's pathway through the diagnostic, staging, and treatment following identification of an upper gastro-intestinal (GI) malignancy is closely monitored and coordinated via the patient pathway coordinators in the different Trusts and the clinical nurse specialists. The patient is central to the final decision of treatment and care, following consultations with the relevant upper GI clinicians and the clinical nurse specialists.

Prostate cancer

Category: Cancer
Eligible: Yes
Participating: Yes
Percentage of cases submitted: Not available
Actions to improve: Update not currently available

Head and Neck cancer (DAHNO)

Category: Cancer
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The key challenges are that there has been a year-on-year rise in the number of cases seen by the specialist multidisciplinary team and, in addition, the Trust is an outlier in the time it takes from diagnosis to surgery. The national average time for radical surgery from decision to treatment is 28 days but at the Trust it is 38 days, which is the longest interval in the audit. This is a deteriorating performance as the previous audit was 35 days. One year crude mortality is lower than national rates.

Acute Coronary Syndrome or Acute Myocardial Infarction (MNAP)

Category: Heart
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.

Cardiac Rhythm Management (CRM)

Category: Heart
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.

Coronary Angioplasty/National Audit of PCI

Category: Heart
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.

National Cardiac Arrest Audit (NCAA)

Category: Heart
Eligible: Yes
Participating: No
Percentage of cases submitted: Not applicable
Actions to improve: Participation requires subscription to the NCAA. To date, the Resuscitation Operational Management Group (ROMG) has decided not to subscribe as it is costly with no real benefit to the Trust. Instead, for a number of years we have carried out an annual local audit of cardiac arrest data that is more comprehensive than the national audit and therefore more valuable. Results of the local audit are consistently high. The ROMG will however, periodically review whether it is beneficial to subscribe to the NCAA.
Section 03

National Vascular Registry
Category: Heart
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The Trust continues to submit data to a high level of completeness.

Rheumatoid and Early Inflammatory Arthritis
Category: Long term conditions
Eligible: Yes
Participating: Yes
Percentage of cases submitted: Not applicable - data collection
Actions to improve: It is expected that the first results for this audit will be available in June 2015, and the first annual report is due to be published in Autumn 2015.

Diabetes (Paediatric) (NPDA)
Category: Long term conditions
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The average glycated hemoglobin was favourably comparable to the national average this year. Improved record keeping and improved annual screening, regular foot examination and reviews have commenced from this year.

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
Category: Long term conditions
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The final report and comparative patient data has not yet been received. The organisational data shows significant variation in practice between the Princess Royal Hospital and the Royal Sussex County Hospital, particularly with regard to the availability of pulmonary rehabilitation and access to an early discharge COPD team. The Trust scored less well with regard to the availability of COPD nurses and multi-disciplinary team, regular use of COPD discharge care packages and provision of pulmonary rehabilitation, and COPD. Actions will include the appointment of a further COPD Clinical Nurse Specialist, improvements in the care provided following discharge and the planned appointment of a new COPD Consultant.

National Adult Cardiac Surgery Audit
Category: Heart
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The outcomes data are presented on a monthly basis within the Cardiac Surgery Clinical Governance and Management meetings and the department has evolved a process to look at outcomes other than death to improve patient care.

Heart Failure
Category: Heart
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.
**Inflammatory Bowel Disease (IBD) programme**

**Category:** Long term conditions  
**Eligible:** Yes  
**Participating:** Yes  
**Percentage of cases submitted:** 98%

**Actions to improve:** An ongoing action plan has resulted in the following: Getting patient information produced in-house for the clinics, who now have new patient packs, service information sheets, guides for self-treatment of colitis flares and new steroid information sheets; Working with the obstetricians to develop a shared pathway for managing IBD patients in pregnancy; Improved surgical attendance at the Multidisciplinary Meeting (MDM) and planning for a new joint super-clinic with them; Formalising the way that the MDM works and planning a new virtual clinic to optimise the management of all IBD patients on biologics; Setting up a pharmacist-led drug monitoring service with dedicated clinics to improve outcomes and safety (this service has been nominated for two national pharmacy awards); Developing a post-op pathway for Crohn’s patients to ensure that we are not missing opportunities for disease optimisation; Securing funds for a pilot program of providing formal psychological support to IBD patients; Developing an iron deficiency/infusion/monitoring service for IBD patients.

**Renal replacement therapy (Renal Registry)**

**Category:** Long term conditions  
**Eligible:** Yes  
**Participating:** Yes  
**Percentage of cases submitted:** 100%

**Actions to improve:** The Trust makes automated submissions to the UK Renal Registry every year via the Sussex Kidney Unit (SKU). The SKU holds 13 Clinical Governance Meetings (CGM) each year, and there is an audit presentation at each of these meetings, each of which results in the development of an action plan. After-action reviews of cases that are of concern are also regularly presented and all renal deaths are reviewed at the CGM on a monthly basis.

**Sentinel Stroke National Audit Programme (SSNAP)**

**Category:** Older People  
**Eligible:** Yes  
**Participating:** Yes  
**Percentage of cases submitted:** 100%

**Actions to improve:** The Trust has achieved band A for both case ascertainment and audit compliance. Reports have been circulated to all members of the multidisciplinary team and a summary report has been written and circulated and presented to the bi-monthly stroke clinical governance meeting, commissioners and pan-Sussex stroke group. There is ongoing discussion with the pan-Sussex stroke group regarding changes to services in Sussex.

**Falls and Fragility Fractures Audit Programme (FFFAP)**

**Category:** Older People  
**Eligible:** Yes  
**Participating:** Yes  
**Percentage of cases submitted:** 100%

**Actions to improve:** The Trust submits data regularly to the National Hip Fracture Database and data completeness and on-going monitoring by the audit officer is undertaken continuously. Preparations are now being made to allow the Trust to participate in the Inpatient Falls audit scheduled for May 2015.

**National Audit of Dementia**

**Category:** Older People  
**Eligible:** Yes  
**Participating:** Not applicable  
**Percentage of cases submitted:** Not applicable

**Actions to improve:** There was no data collection in 2014-15 and the next data collection phase is due to start in April 2016.

**Elective surgery (National PROMs Programme)**

**Category:** Other  
**Eligible:** Yes  
**Participating:** Yes  
**Percentage of cases submitted:** 77.9%

**Actions to improve:** The latest overall participation rate of 77.9% is just above the England average of 76.7%. Whilst the Trust’s participation rates for groin hernia repair and varicose vein surgery have remained considerably higher than the national average, participation in the orthopaedic procedures has been lower. However, major efforts in these areas have led to a steady improvement over the latter part of the year and these are expected to show a significantly higher rate of participation for the next audit year.

**Paediatric Intensive Care Audit Network (PICANet)**

**Category:** Women’s and Children’s Health  
**Eligible:** Yes  
**Participating:** Yes  
**Percentage of cases submitted:** 100%

**Actions to improve:** Results of this audit show that the Trust continues to have some of the lowest mortality rates in the country.

**Fitting Child (Care in Emergency Departments)**

**Category:** Women’s and Children’s Health  
**Eligible:** Yes  
**Participating:** No  
**Percentage of cases submitted:** Not applicable

**Actions to improve:** An administrative error meant that the Trust did not register to participate. For relevant future audits, the Trust’s Paediatric A&E and Adult A&E departments will register as two separate units.
Mental Health (Care in Emergency Departments)
Category: Mental Health
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The report is scheduled for publication in May/June 2015.

Older People (Care in Emergency Departments)
Category: Older People
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The report is scheduled for publication in May/June 2015.

Epilepsy12
Category: Women’s and Children’s Health
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: All children who were eligible were entered into the audit and although the numbers were quite low, this was recognised nationally. The service has consultant paediatricians with expertise in epilepsy in both the acute and community setting and the part-time Epilepsy Nurse Specialist (ENS) works across both acute and community services, maintaining good links. The service is currently looking at different ways of ensuring that all children diagnosed with epilepsy are referred to the ENS and may employ a second nurse to provide a total of one full-time equivalent.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
Category: Women’s and Children’s Health
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: Submission is via an online database. MBRRACE-UK perform cross-checks with the UK birth record database.

Neonatal Intensive and Special Care (NNAP)
Category: Women’s and Children’s Health
Eligible: Yes
Participating: Yes
Percentage of cases submitted: 100%
Actions to improve: The most recent audit showed that approximately 20% of patients did not have their body temperature within target range on admission to the unit. A local audit is therefore planned to look into this further.
Teams and specialties across the Trust have undertaken a wide range of local clinical audits in 2014/15. The reports below are a representative sample of those local clinical audits which were reviewed by the Trust in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided.

**Ophthalmology**

**Project title:** Osteo-Odonto-Keratoprosthesis (OOKP) Service Audit  
**Comments and actions to improve quality of care:** Patients were very satisfied with the OOKP service.

**Project title:** Posterior Capsule rupture rate  
**Comments and actions to improve quality of care:** All categories of surgeons were within the study’s target percentages.

**Physiotherapy**

**Project title:** Audit of pre- and post- interventional functional scores for patients attending a physiotherapist-led lower-limb therapy class  
**Comments and actions to improve quality of care:** The audit was helpful in highlighting the conditions that responded well to the therapy classes and those that did less well. This means that the physiotherapists are able to provide a better idea to patients of the likely benefits of the classes and the number of sessions required.

**Radiotherapy**

**Project title:** Emergency admissions in colorectal cancer: retrospective audit  
**Comments and actions to improve quality of care:** This has helped changes in the management of emergency admissions with gastrointestinal cancer.

**Project title:** Audit of changed process for sending breast images from a different computer system.  
**Comments and actions to improve quality of care:** Changes implemented to the process following initial problems resolved the issues. An altered process can be safely implemented across the department.

**Neonatology**

**Project title:** Proposal for Saturation Screening for Congenital Heart Diseases  
**Comments and actions to improve quality of care:** Research evidence in support of this tool is evolving. We aim to become one of a few pilot sites in the country for Newborn and Infant Physical Examination (NIPE) screening for congenital heart diseases.

**Project title:** Gastroschisis Audit  
**Comments and actions to improve quality of care:** Outcome very good compared to national data. Care immediately after surgery requires some minor refinements and an audit will present data at speciality conference.

**Diabetes/Endocrine**

**Project title:** Endocrine follow-up after severe brain injury  
**Comments and actions to improve quality of care:** Two thirds of patients had no pituitary function tests checked. A pituitary function ‘checklist’ has been developed with tests to be co-ordinated by Head Injury Specialist Nurses in collaboration with rehabilitation units and primary care.

**Speech and Language Therapy**

**Project title:** An analysis of the usefulness of perceptual voice assessment and patient report to determine treatment approach in the voice clinic.  
**Comments and actions to improve quality of care:** Current perceptual assessment and qualitative patient report is a good predictor of treatment approach for people with voice problems. Alternative assessments need to be used to identify vocal tract dryness.

**Digestive Diseases**

**Project title:** Joint Advisory Group (JAG) audits  
**Comments and actions to improve quality of care:** The Gastrointestinal Endoscopy units across the Trust received accreditation from JAG for the standards of work in the units.
Dietetics

Project title: Audit of renal diabetes patients’ dietary and medical management
Comments and actions to improve quality of care: Reduction in gliclazide usage, improvements in education materials, and dedicated diabetes nurse time to dialysis unit.

Project title: FODMAP (Fermentable Oligo-Di-Monosaccharides and Polyols) services for Irritable Bowel Syndrome management
Comments and actions to improve quality of care: Analysis of dietetic effectiveness to manage disease severity and outcomes for this group has shown we have a significant 82% reduction in disease severity which would improve patient care and reduce medication use.

Imaging

Project title: Trouble-shooting Service Survey
Comments and actions to improve quality of care: Changes to Trouble Shooting Standard Operating Procedure.

Project title: Computed tomographic colonography (CTC) Audit
Comments and actions to improve quality of care: Introduction of faecal tagging, buscopan Patient Group Direction changed to allow greater drug use flexibility.

Dermatology

Project title: Surgical excision margins
Comments and actions to improve quality of care: 96% overall skin lesions excised by greater than or equal to 1mm margin, exceeding the 90% target reported by other centres.

Renal

Project title: End of life care
Comments and actions to improve quality of care: Business Case to be developed to assess feasibility of Mutated Colorectal Cancer (MCC) clinics; set up telephone consultation clinic; improve recording of place of death and other RIP details; screens to be reviewed to improve co-morbidity reporting; review job plans to address lack of nursing time for advance care planning.

Project title: Biopsy Audit
Comments and actions to improve quality of care: Audit team to look at other data sources (e.g. Italian Registry data) for comparison with any published work of the diagnosis following biopsy. Agreed that for biopsies where the tumour can’t be measured that are over 3/12, two cores would be taken unless there is a technical reason for one core only. Chorionic Villus Biopsy (CV5) to be trialled for four weeks to improve recording of biopsy details and discuss at clinical governance meeting.

Care of the elderly

Project title: Benzodiazepine use on the elderly care wards
Comments and actions to improve quality of care: Education sessions for staff have focussed on the advice set out by the Royal College of Physicians ‘FallSafe’ Project, including: ensuring patients have regular medication reviews where consideration is given to possible alternatives or gradual withdrawal of the drug; reinforcing the need for clear documentation of the decision to either continue or stop medications; and providing educational material and support to patients and/or carers to improve understanding of the risks of benzodiazepine misuse.
A&E

Project title: Missed Radiology Audit in the Emergency Department
Comments and actions to improve quality of care: Results showed that 0.7% of pathology was missed. Reporting times on x-rays had improved from the previous audit and a larger number of letters were being sent to GPs recommending six week repeat chest x-rays. Recommendations include: introduce better filtering out of normal scans; all discharges to have a six-week follow up recommended if abnormal chest pathology; quicker reporting of scans is recommended; doctors to ensure scan abnormalities are recorded on the A&E information system.
Participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. The number of patients receiving NHS services that were recruited in 2014/15 to participate in research approved by a research ethics committee was 3,834. The Trust was involved in conducting 198 clinical research studies across 25 clinical specialities during 2014/15.

There were over 350 clinical staff participating in research, of which 117 are employed specifically to support the delivery of research approved by a research ethics committee during 2014/15. Also, in the last three years, 331 publications have resulted from our involvement in National Institute for Health Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Developing our research activity

Over the past two years we have looked to invest imaginatively in the growth of research in areas such as A&E, orthopaedics and heart failure. The injuries and emergencies research portfolio is varied and challenging due to the acuity of patients’ condition and the unpredictability of their presentation. At the Trust these consultant-led studies are delivered by a small team of three research nurses led by Carrie Ridley and Consultant Maria Finn. The nurses provide a 24/7 on-call service for out-of-hours patients to ensure that all eligible patients are screened for entry into trials.

They demonstrate advanced clinical skills delivering complex research protocols on unwell patients, as well as an expert working knowledge of the emergency consent process including entering adults lacking capacity and use of emergency consent. This is without doubt a very challenging and busy environment to work in, let alone try to conduct research that requires time and space. We are delighted this investment has paid off and thanks to the team, we have successfully recruited our first ever patient to a commercial drug study in A&E and only the second patient to this study in the UK. It is hoped that this will pave the way for more research in this niche area. Trauma research has also taken off successfully in the past 12 months, thanks to the hard work of the research team, led by Consultant Orthopaedic Surgeon Mr Benedict Rogers whose enthusiasm and energy have led to the expansion of this challenging research portfolio. The Trust has become established as a respected centre for Trauma and Orthopaedic research and is now highly regarded by national and international collaborators.

BSUH’s recruitment to the recent hip fracture was amongst the highest in the country, surpassing recruitment targets by 187%.

We have also started to expand within established research specialities, delivering equal success. Cardiology has long been a leading research area within the Trust, but in the last year we have diversified our portfolio to include studies across the speciality. Once more this has resulted in some excellent outcomes for our patients with the Royal Sussex County Hospital becoming the joint top recruiter in the UK for a recent heart failure study.

Brighton and Sussex Clinical Trial Unit (CTU)

The CTU is on track to submit an application for formal registration with the UKCRN. Operational Lead Nicky Perry is currently preparing the application in time for the May 2015 deadline.

Spotlight on - Patient and Public Involvement and Engagement Group

The ‘Jaffa’ Panel is a patient and public involvement (PPI) lay research panel based at the Trust. It meets weekly to give researchers the opportunity for an early lay review of their research ideas. The group helps to ensure that the research questions and topics are relevant to patients. It also reviews written materials, including plain English research summaries and patient information sheets. The panel currently has 10 active members, with ages ranging from 16 to 83. There is a very welcoming and inclusive dynamic, where discussion flows freely between the generations.

The Jaffa Panel (so called because Jaffa Cakes are their biscuit of choice at meetings) feature in the latest INVOLVE winter 2014-15 Newsletter (www.involve.nihr.ac.uk/posttypenewsletter/winter-2014-15/) with a summary of the work they presented at the INVOLVE Conference in November 2014. The article recognises some of the excellent work undertaken by the panel on behalf of the Trust and highlights the benefits of patient and public involvement in research. It is encouraging to see such enthusiasm and recognition for the work done by the Jaffa group for and on behalf of the Trust.
As the regional teaching hospital our staff are heavily engaged in clinical trial and research project development as well as participating in national programmes of activity.
Care Quality Commission

The Trust is required to register with the Care Quality Commission and is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2014/15.

CQC Inspection

The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 21st to 23rd May 2014. A team of 35 inspectors visited four of the Trust’s eight registered hospital sites and conducted further unannounced spot checks on the 27th May and 30th May.

The Trust received an overall rating of ‘requires improvement’ and ratings for the five domains, assessed by CQC as below:

| Are the services at this Trust safe? | Requires improvement |
| Are the services at this Trust effective? | Good |
| Are the services at this Trust caring? | Good |
| Are the services at this Trust responsive? | Requires improvement |
| Are the services at this Trust well-led? | Requires improvement |

### Ratings for the Royal Sussex County Hospital

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
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</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Requires improvement</td>
<td>Not rated</td>
<td>Good</td>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Medical care</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Surgery</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Critical care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity &amp; family planning</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Children &amp; young people</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
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</table>
There were eight compliance actions which focused around areas which had already been identified by the Trust prior to the CQC visit. These included:

- Patient flow which was having an impact on care and patient experience in the Emergency Department and on the wards and also on the planning and support that people received when they were ready to leave hospital.
- The implementation of the centralised booking system which had caused problems for patients and staff alike.
- Staffing levels and the high use of bank and agency staff.
- Learning lessons and ensuring that staff reporting incidents receive feedback.
- Cultural issues, including engagement with staff, and race equality; and appraisal and training rates.
- Improvements to the hospital environment on the Royal Sussex County site.

CQC also noted outstanding areas within its reports as follows:

- The Trust was exceptionally open and engaged with the inspection.
- Awareness of staff of the work on values and behaviours was almost universal.
- Care for patients with dementia was very good in both the Royal Sussex and Princess Royal Hospitals, where staff had been innovative and creative in order to provide a safe and stimulating environment for people.
- The critical care teams at the Royal Sussex and Princess Royal Hospitals were strong, committed and compassionate.

Following the inspection, the CQC convened a Quality Summit on 5th August 2014, where the report, its recommendations and the Trust action plan were reviewed. The Quality Summit was attended by members of the Board and external stakeholders, including commissioners, NHS England and the NHS Trust Development Authority (TDA).

The action plan was submitted to the CQC in September 2014 and progress is reviewed regularly by the Board. As discussed elsewhere in this report, challenges continue in making sustained improvements to patient flow. However, the nurse recruitment programme has been successful and over 205 nurses have been offered posts, which will reduce the dependence on bank and agency staff. The results from the latest national staff survey also show that we have more work to do to improve staff engagement. Our new People and Well-being Strategy will start to address this.
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Data quality

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

- Updated processes to improve the accuracy and completion of data collected at source
- Monthly data cleansing prior to submission of data to the Secondary Uses Service (SUS)
- Synchronised matching of local data fields with that of the national spine
- Regular reviews and audit of clinical coding related data
- Implementation of any recommendations arising from the National Payment by Results (PbR) assurance programmes
- Regular monitoring of key indicators by the Trusts Information Governance Committee

NHS number and general medical practice code validity

The Trust submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient’s valid NHS number was:
  - 98.7% for admitted patient care;
  - 99.3% for outpatient care; and
  - 91.0% for accident and emergency care

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit (reported April 2014) for that period (2013/14) for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect - 11.6%
- Secondary Diagnoses Incorrect - 12.2%
- Primary Procedures Incorrect - 6%
- Secondary Procedures Incorrect - 13%

Information governance toolkit attainment levels

The Trust scored 66% in the information governance toolkit assessment. Our 2014/15 submission was level 2 which is classed as a satisfactory grade and therefore is green based on the following key:

<table>
<thead>
<tr>
<th>Not Satisfactory</th>
<th>Satisfactory with improvement plan</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓</td>
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</tbody>
</table>

Clinical coding error rate

A proportion of the Trust’s income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Commissioning for Quality and Innovation (CQUIN)

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at http://www.bsuh.nhs.uk/about-us/performance-and-data/
Statement of assurance from the Board

During 2014/15, the Trust provided a wide range of hospital services across two main hospital sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath, together with services at The Park Centre for Breast Care; Hove Polyclinic; Lewes Victoria Hospital; Brighton General Hospital and Bexhill Hospital. We provide District General Hospital services to our local populations in and around the city of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the South East of England.

The Trust has reviewed all the data available on the quality of care in all of these NHS services, through our performance framework and quality governance arrangements. The income generated by the NHS services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2014/15.

Statement of Directors’ responsibilities

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements). In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

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

The content of this report and our quality improvement priorities were agreed with the Trust’s Executive Team, Clinical Directors through our Clinical Management Board and our Board Quality and Risk Committee. Our priorities follow consultation with our clinical directorates, commissioners, other local providers and patient groups.

The report has been reviewed by our commissioners, Local Authority partners and patient groups and their comments are included in Section Five.

By order of the Board

Matthew Kershaw
Chief Executive

Julian Lee
Chairman

This is subject to approval by the Board of Directors on 6 July.
Independent auditors’ report

We are required to perform an independent assurance engagement in respect of Brighton and Sussex University Hospitals NHS Trust’s Quality Account for the year ended 31 March 2015 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- FFT patient element score.
- Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations). In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH on insert date (“the Guidance”);
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated June 2015;
- feedback from Local Healthwatch dated June 2015;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated June 2014;
- the latest national staff survey dated December 2014:
Section 03

- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 23 April 2015;
- the annual governance statement dated 9 June 2015;
- the Care Quality Commission’s quality and risk profiles (now intelligent monitoring report) dated January 2015;
- the results of the Payment by Results coding review dated April 2015.

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

This report, including the conclusion, is made solely to the Board of Directors of Brighton and Sussex University Hospitals NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Brighton and Sussex University Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

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

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Brighton and Sussex University Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Ernst and Young LLP
Reading
28 June 2015
“From the first time we visited we felt reassured at how our aunt was being cared for and treated in a medical and personal way.”
Safety and quality priorities

We identified the below priorities following discussions with patient groups, commissioners, other providers and Trust staff. They have been chosen because they will have the most impact on the safe experience of patients.

- Improving care for frailty patients
- Improving care for deteriorating patients - Sepsis
- Improving care for deteriorating patients - Acute Kidney Injury (AKI)

We plan to continue the development of the service and are working to further streamline and support all elements of the patient’s journey and the overall care delivery.

We aim to improve the early identification and treatment of patients at risk of sepsis on arrival to the hospital via the Emergency Department or by direct emergency admission to another unit or acute ward.

We aim to improve the follow-up and recovery for individuals who have sustained an AKI, reducing the risks of readmission, re-establishing medication for other long term conditions and improving follow-up.
Measuring the progress of our priorities

Improving care for frailty patients

During 2015/16 we plan to continue the development of the service as described on page 14 of these accounts. We are currently working on the paperwork to support frailty care which will further streamline and support all elements of the patient’s care. Our progress will be based on the package of care we are creating and which will provide a source of data for measurement.

Improving care deteriorating patients - sepsis

We have agreed performance targets to measure improvement for sepsis as part of the Commissioning for Quality and Innovation (CQUIN) programme for 2015/16. These involve:

- Screening for risk of sepsis
- Performing tests to confirm diagnosis
- Initiating intravenous antibiotics within one hour of presentation

Improving care deteriorating patients - Acute Kidney Injury

We have agreed performance targets to measure improvement for AKI as part of the Commissioning for Quality and Innovation (CQUIN) programme for 2015/16. These involve:

- Alerting clinicians that their patient has sustained an AKI (using pathology reporting systems)
- Improving medication reviews
- Improving the information communicated to primary care relating to ongoing management after discharge

Progress with our three priorities will be monitored by the Executive Safety and Quality Committee and reported to the CCGs, NHS England, local Healthwatch organisations and local overview and scrutiny committees. A formal progress report will be shared every six months.
Our safety pledges

Put safety first

We pledge to commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

We will:

• Publish a comprehensive patient-focused Safety and Quality Strategy which underpins all of the Trust’s activities. This will be displayed prominently on our internal and external websites.

• Maintain and improve our large and significant reduction in patient falls and apply similar improvement strategies to reduce injury from pressure damage and medication errors.

• Develop a learning and reporting culture amongst staff through our ‘Values and Behaviours’ Programme. In addition we will ensure staff reporting incidents receive feedback on their incidents and the lessons are shared across the organisation.

• Continue to reduce hospital-acquired infection through active feedback to ward areas and root cause analysis.

• Focus on safety culture in operating theatres to ensure safer surgery.

Continually learn

We pledge to make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe services are.

We will:

• Actively seek feedback from patients not only on clinical care but also on handling of complaints and serious incident investigation and use this information to drive improvement.

• Develop a network of Safety and Quality leads across the Trust with a specific focus on sharing and embedding learning from patient feedback, incidents and complaints.

• Develop a human factors and simulation faculty who will deliver regular training in human factors for all clinical staff and use real incidents as the basis of training scenarios.

• Develop our ‘Towards a safer hospital’ projects, which take the experience of frontline staff and patient feedback and use it to develop improvement projects led by frontline staff and supported by experts and senior leaders.

• Listen to staff and patients who raise concerns through our Patient Safety Ombudsman and to develop an Advisory Panel including Board members who ensure actions arising from concerns are completed.

• Develop our Medical Examiner system to allow independent review of every death using an adapted ‘Global Trigger Tool’.

• Look for new and innovative ways of involving service users in improving our services.

• Ensure each department has a robust strategy to regularly audit performance to ensure they are delivering care in-line with current best practice.
We pledge to be transparent about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will:

• Continue to notify and discuss all Serious Incidents (SIs) with patients and relatives affected and to provide a copy of the investigation report.

• Include all Serious Incident Notifications and lessons learnt from SIs in the monthly ‘Team Brief’.

• Publicly display key safety data including staffing levels on all wards and keep this data regularly refreshed.

• Train staff in incident investigation and include specific sessions on being open with patients who have been harmed by an incident.

• Build on our strong, clinically-led incident review process to ensure patients and staff receive feedback on the progress of incident investigation.

We pledge to take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will:

• Actively engage with our local Patient Safety Collaborative to share learning and expertise across the region.

• Continue to develop our work on frailty, falls, pressure damage and dementia to create pathways across service providers that improve patient experience and reduce hospital admission.

• Improve our discharge process to ensure safe transfer of care back to community.

• To develop as a Chapter of the Institute for Health Improvement and use the expertise generated to drive improvement.

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We pledge to help people understand why things go wrong and how to put them right, give staff the time and support to improve and celebrate the progress.

We will:

• Build on our experience of ‘Staff Stories’ (using ‘Schwarz Rounds’ methodology) as a forum for staff to share experiences and give support.

• Continue to share anonymised patient stories through the ‘Patients 1st’ newsletter, highlighting how things have gone wrong for patients, what we have learnt from incidents and what we are doing to prevent further patient harm.

• Increase the number of staff receiving After Action Review training, which is a debriefing tool that allows a rapid objective review of an incident.

• Further improve our ‘Innovation Forum’ by allocating small sums of money to selected projects in addition to providing senior expert support.

• Eliminate discrimination on grounds of race or other protected characteristic and ensure equal support to all staff involved in serious incidents.

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Honesty

We pledge to help people understand why things go wrong and how to put them right.
Ten high impact programmes to deliver improvements in safety and quality of care

01 Improving urgent care performance

On an average day around 430 people come to our four Emergency Departments at the Royal Sussex County Hospital; the Royal Alexandra Children’s Hospital; the Sussex Eye Hospital and the Princess Royal Hospital. The national target is that within four hours at least 95% of these patients will be treated and then either go home or move out of the Emergency Department into a ward.

Meeting this target in our main Emergency Departments at the Royal Sussex County Hospital and at the Princess Royal Hospital is a daily challenge for us. We want to make changes so that it is easier for people to leave the Emergency Department as soon as they have received the urgent care that they need.

Some of this is about changes to our hospitals and how we work. For example, if we can care for our patients in a way that reduces the length of time they stay on our wards, then we are more likely to have beds available for people who need to come into hospital urgently.

This year we will redesign the layout of the acute floor at the Royal Sussex County Hospital and change how we assess patients before they are taken to a ward. It is expected that this will mean we can help more people to go home without an overnight stay in hospital.

With the right services outside of hospital, people are less likely to come to hospital and can go home earlier if they do need hospital care. We are working closely with our partner organisations to make this happen.

In 2015/16 we will also be looking at the urgent care given to people who have a stroke. Medical and technological advances in recent years have transformed stroke treatments, making it possible to restore blood flow and improve brain function when areas of the brain are damaged. We will work with other NHS organisations across Sussex to review our services and ensure that together we provide the best possible survival rates, urgent treatment and follow-up care for people who experience a stroke.
Making best use of capacity to improve safety and patient flow

Across our hospital sites we have 896 beds. We estimate that we need about 5% more beds to be able to give patients the best care and allow our staff to be most effective. We are looking at ways to create additional beds at the Royal Sussex County Hospital.

We will be working closely with Sussex Community NHS Trust to look at how people can be cared for when they no longer need acute hospital care but are not able to go home. For example, we want to open a ward in NHS premises in Newhaven for some of these patients to recover with good therapeutic support, away from the busy Royal Sussex County Hospital.

5% more beds needed to give patients the best care

Delivering site reconfiguration

A number of service and site changes will take place in June 2015.

All emergency and cranial neurosurgery will move from the Princess Royal Hospital campus in Haywards Heath to the Royal Sussex County Hospital in Brighton as part of the major trauma centre. Capital works are being undertaken to upgrade two day surgery theatres to neurosurgical theatres, creating four additional ITU beds, a bi-planer angiography suite and a dedicated inpatient ward.

The neurosurgical unit will be co-located on the acute floor, adjacent to the Emergency Department.

A dedicated service will be created at the Princess Royal Hospital campus for patients with a fractured neck of femur, supporting implementation of the enhanced recovery programme and reducing the time patients stay in hospital.
Inpatient urology services will be brought together to create a centre of excellence at the Princess Royal Hospital.

Following these moves we will make some changes to the interior of the Hurstwood Park Centre at Princess Royal Hospital, enabling further service moves:

- A dedicated day case surgical unit will be created in the Hurstwood Park Centre, for patients requiring breast, endocrine, ENT (Ear, Nose, Throat) or maxillo-facial surgical treatment.
- Creation of a haem-oncology day case treatment area in the Hurstwood Park Centre.
- Provision for theatre-based simulation training in the Hurstwood Park Centre.

A considerable amount of work has gone into planning for these moves and developing the models of care involved.

In 2015/16 we will also continue the 3Ts redevelopment programme (Teaching, Trauma and Tertiary Care), to replace outdated accommodation for patients at the Royal Sussex County Hospital and to expand our capacity for key specialties across Sussex. This involves two major new buildings, the first of which is expected to be ready by 2019 and the second by 2022. The whole programme will be completed by the construction of a new service yard in 2023.

Before we can build we need to move services out of buildings which will be cleared to make space for the development. In 2015/16 we plan to:

- Complete the front car park building (in front of the east wing of the Barry Building) which will house Nuclear Medicine, Radiopharmacy, Physiotherapy and Rheumatology during the building project;
- Complete the courtyard building and move the wards currently in the Jubilee block;
- Replace the old portacabins on the North Service Road, adjacent to the A&E car park, with a new Clinical Administration Building to accommodate a range of non-clinical services and facilities.
- Start clearing the site for the first of the redevelopment’s new buildings.

We expect to secure full business case approval later this year, allowing us to receive the significant investment needed for this major hospital redevelopment programme.
04 Improving the effectiveness of our workforce across the whole week

Our hospitals never close - 24 hours a day, 7 days a week we are providing care and treatment for patients. But we want to do more to help people see expert clinicians, get a diagnosis and start treatment on Saturdays and Sundays.

There is evidence that increasing the numbers of doctors in hospitals over the weekend can increase survival rates. It could also help us to make best use of our buildings and equipment, reducing the pressure on our services Monday to Friday and helping patients to leave hospital sooner.

This involves working with our doctors, nurses, therapists and other health professionals to make sure we have the right workforce to support 7-day services. We will also be looking at how we staff our hospitals at night to ensure our staff are fully supported and we provide the best possible care to patients.

Increasing numbers of doctors in hospitals over the weekend can increase survival rates

05 Strengthening our specialist services across Sussex

We provide specialist services for people across the South East of England. This includes vascular, cardiac, renal and radiotherapy services. We will continue to work with our partners to develop these services and recruit the right specialist staff to provide excellent patient care.

For example, currently if you live in East Sussex and need radiotherapy you have to travel to Brighton or Maidstone. In 2015/16, a £15m investment will provide two Linacs (linear accelerator machines used to deliver radiotherapy) and a modern, fully equipped radiotherapy facility run by the Trust at Eastbourne District General Hospital.

We will also look at how we manage our beds in order to make sure that patients who need highly specialised care are less affected by the peaks and troughs of urgent care for our local population.
Strategic service developments with focus on recovery of 18-weeks, cancer and diagnostic standards for key service areas

The NHS Constitution gives patients who do not need immediate medical treatment through the Emergency Department the right to begin treatment within a maximum waiting time of 18 weeks from referral. In a busy hospital treating many urgent patients, it is sometimes difficult for us to meet this standard.

To make sure we treat all our patients in a timely way we need to make the best possible use of outpatient and theatre time, and are also working to make sure that the information we hold about waiting times is 100% accurate.

We are putting on extra sessions in services which are particularly stretched, including investing in our digestive diseases department.

We are creating an integrated elective spinal service at the Princess Royal Hospital, bringing all our elective spinal surgery together on a single site.

Organisational change to better support service delivery

For example, in July 2015 staff currently employed by Sodexo will join the Trust. An internal team is working to make sure all services are sustained and strengthened during this transition and that all our staff experience a working environment in which they can thrive.

We are committed to filling our vacancies to reduce our reliance on agency staff, valuing difference and working in partnership with staff and their representatives.
08 Refresh of the Clinical Strategy in the context of the national NHS five year forward view

The NHS five year forward view, published by NHS England, describes new ways of organisations working together to care for patients. We will look at what options this gives us for partnership working across Sussex and beyond.

In 2015/16 we will also work with our clinical commissioning groups and the Sussex MSK Partnership to reshape musculo-skeletal services for patients.

09 Introduce the next phase of our people/change/Values and Behaviours programme

In 2015/16 we will focus on developing our leaders, engaging with our staff and ensuring everyone has a meaningful appraisal about their contribution to patient care and their personal development.

We will also create a clear process for managing organisational change. This will help us to prioritise the right work and take a rigorous approach in order to make sure we complete the process of change. We want to do fewer projects and do them really well.

Our Values and Behaviours programme will help us to ensure all staff have an appraisal and that these are carried out in a way that supports personal development and engages our staff in making improvements.

We will restructure the HR department to allow us to more effectively support staff wellbeing and personal development.
In 2015/16 we will receive about £440m for clinical services and about £75m for other activity such as research and training.

In order to invest in service developments and improvements in 2015/16, we must make savings. We plan to make changes to the way we work in areas including procurement and length of stay, which will save £32m within the year; we will spend that on new developments like those described earlier.

We will particularly focus on reducing the amount we spend on temporary doctors and nurses. Recruiting and retaining the right staff is better value for money and better for continuity of patient care.

We have had to make careful choices about what improvements we will invest in. These decisions have been made with the help of the clinical directorates, focussing on areas where we can make a real difference for our patients and staff.
“I will never forget the outstanding care and compassion shown by staff in all areas.”
The Trust is grateful to our partners for helping us identify our quality improvement priorities and for their comments on the draft report. Their comments have been incorporated to make the final account more accessible and clear for members of the public.

Healthwatch Brighton and Hove

In general terms, we note that there are some positive stories in this year’s quality account which should be highlighted and supported. These include the reduction in serious infections such as MRSA and Clostridium difficile, the implementation of the Enhanced Recovery Programme to improve people’s recovery times when they have had operations, and work around the values, behaviours, and innovation of NHS staff across the organisation.

Healthwatch Brighton and Hove also supports the programme of monitoring care and compassion through methods such as the ‘Sit and See’ observational tool. Healthwatch staff and volunteers have been trained in using this tool, and would welcome a conversation with the Trust about how to add value to the observations that are already taking place.

Patient experience

Healthwatch takes its lead from the comments and responses received from patients and the public. In summary the main areas of concern we have heard or experienced during our visits this year relate to:

- Significant waiting times in A&E.
- Cancelled operations - often at short notice.
- Poor quality basic care in the Acute Medical Unit with elderly people and/or those with dementia being particularly vulnerable and/or inappropriately placed.
- A lack of consistency with regard to the Mental Capacity Act/Deprivation of Liberty Safeguards and its appropriate application.
- In some cases social care packages for discharge not in place (mostly where needs were complex).
- Muscular Skeletal, Abdominal Surgery and Medicine.

Furthermore, the issues have remained unchanged despite a range of interventions by the Trust and other parties. It would be a significant development to reduce the number of issues arising from these departments next year.

We are pleased that systems such as the Friends and Family Test, Patients’ Voice survey and National Patient Satisfaction Survey are a part of regular monitoring at the Trust. Whilst implementation is not yet up to the required standards in all areas presently, a firm start has been made. Mechanisms like the patient experience panel also have the potential to ensure the patient’s experiences are at the heart of decisions made at the hospital.

Like our colleagues in Healthwatch West Sussex, Healthwatch Brighton and Hove would have expected to see some analysis of the issues identified through the Patients’ Voice processes (e.g. PALS, Complaints, Friends and Families Test) but the QA Report deals with this as a statistical issue.

The goal for 2015/16 may be a measurable one but in the absence of qualitative detail, it’s not clear if the goal will be meaningful and lead to any improvement in patient experience.

Finally, we would also agree with colleagues that the reporting format is not public friendly and we would urge the Trust to consider producing an accessible summary that addresses that point.
Discharges and readmissions

Some of the key themes from our report ‘Leaving Royal Sussex County Hospital’ were around people feeling they were discharged with little warning, and that carers often felt left out of the discharge process. When people leave hospital feeling unsure about the next steps, or without full carer understanding and support, there can be implications on things like readmission rates back into the hospital. Healthwatch supports the implementation of systems such as discharge hour, which allows medications to be prepared 24 hours before discharge, to ensure they will not need to wait excessively when patients are fit and ready to leave. However, we were disappointed that it took seven months after our report was released for a discharge booklet to be produced.

The issues with discharges were further reflected in our report on older people’s care in the Royal Sussex County Hospital, where we conducted an unannounced visit of Chichester Ward, Emerald Ward, Overton Ward and the Acute Medical Unit. On the day we observed good practice on the topics of dementia care and support and the caring attitude of individual staff members towards their patients. However, we also found that 63% of patients on the wards we visited were medically fit to leave the hospital, but were waiting for social care packages to be put in place first. Patient flow and discharge are issues that were highlighted through a recent CQC inspection, and Healthwatch continues to monitor work around these issues with the Trust.

Acute Medical Unit

As the Trust is aware, alongside our colleagues in East and West Sussex Healthwatch, we have significant concerns about the care of patients in the Acute Medical Unit. As the Trust is also aware we escalated these issues to the CQC following ongoing problematic feedback from patients. Although we welcome the action plan the Trust has developed in response to this internally, we are disappointed to see that specific and clear reference to the Unit and plans to address patient safety and quality are not expressly mentioned.

Conclusions

We are pleased to report that Healthwatch Brighton and Hove has a positive relationship with the Trust. We meet regularly with the CEO and senior staff and are active members of the Patient Experience Panel. We have undertaken ‘Enter and View’ visits and plan to do more; specifically in relation to the patient journey from admission at A&E with a focus on frail older people.

Furthermore, we have recently undergone ‘Sit and See’ training and wish to work collaboratively with the Trust to use this tool to gather further patient experience data. We find the senior management team of the Trust to be open to collaboration and the role of Healthwatch as a critical friend.

The aspirations the Trust articulates seem appropriate and correct but we remain concerned that performance is mixed both from our own experience and that of the CQC inspection result of ‘requires improvement’. Given that this included the domain of ‘well-led services’ it is particularly important that the aspirations are translated into meaningful action.

Finally, it would appear that a systematic review of the model of care in relation to emergency admission and acute services is required and we urge the Trust to publicly articulate its plan to improve the Acute Medical Unit in particular.
Clinical Commissioning Groups of Brighton and Hove; Crawley, Horsham and Mid-Sussex, and High Weald Lewes Havens

The Quality account appears to comply with the NHS England guidance on the content of the Account.

The CCGs are pleased to see that the Quality Account priorities have taken into account both national and local priorities for secondary care, and reflect concerns raised by the CQC during their inspection visits during 2014.

We would commend the Trust in terms of having committed, caring and compassionate staff, evidenced in assurance visits that the CCG quality managers have undertaken through the year. We also recognise the progress which has been made in a number of areas including in the enhanced recovery programs and with good involvement in National audits.

It is recognised however that the Trust has had many challenges in meeting expected levels of performance not only in Emergency Care and the impact that has had on patient experience and the organisations ability to deliver a number of other key quality standards in areas of planned care and diagnostic services.

CCGs recognise the challenges the Trust has had with staffing shortages and the positive recruitment work which has been undertaken to improving, in particular nurse staffing levels.

We also note the positive focused work to address cultural issues identified by the CQC and staff survey results, supported by the values and behaviours program and the people strategy. In noting this positive work this does not detract from the need for staff to have committed support to access education and training including statutory/mandatory training and high quality appraisals, which the CCGs continue to require assurance.

Developing the new clinical structure to deliver improved accountability and leadership aligned with patient pathways is recognised as an extensive piece of work. With strong clinical and management teams working together with system partners, we look forward to seeing the positive outputs of this structure resulting in supporting the transformation of care pathways both internally and out of hospital in order to deliver the system wide aspiration to improve in particular, personalised proactive care for those with long term conditions, and those who are vulnerable and frail in line with the Five Year Forward View.

Brighton and Hove CCG with their partner CCGs look forward to continuing to work closely over the coming year with Brighton and Sussex University Hospitals Trust to take forward at pace the work started to address the systemic issues impacting upon services.

Health and Adult Social Care Select Committee (HASC)

HASC is pleased with the progress made in reduced mortality and infection rates and with the care of patients with dementia in the Trust’s hospitals.

There remain concerns over ambulance handover times, particularly at the Royal Sussex County Hospital, which affect patient flow and experience throughout the hospital. HASC liaison members continue to monitor this issue with the Trust and also with South East Coast Ambulance Service NHS Foundation Trust to understand and support the improvements that are required.

In June 2014, HASC endorsed the Trust’s proposals for the reconfiguration of clinical services and welcomed plans for the implementation and performance of the Sussex Vascular Service.

Finally, HASC welcomes the Trust’s safety priorities, pledges and ten high impact programmes to deliver improvements in safety and quality of care and will continue to monitor and support work to deliver these.