Brighton and Sussex University Hospitals
NHS Trust

Quality Accounts 2018-19

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Part 1: Statement on Quality from the Chief Executive Officer

What we do

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital working across two main sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital and is also the Major Trauma Centre for the region.

We provide 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. The Royal Sussex County Hospital has a 24/7 Emergency Department (ED) for its local population and is also is our centre for emergency and tertiary care. The Princess Royal Hospital also has a 24/7 Emergency Department (ED) for its local population and is our centre for elective surgery.

Our specialised and tertiary services include neurosciences, arterial vascular surgery, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. In addition to our two main hospital sites we also provide services from Brighton General Hospital, Hove Polyclinic, Lewes Victoria Hospital, the Park Centre for Breast Care and a renal dialysis satellite service in Bexhill, East Sussex.

Central to our ambition is our role as an academic centre, provider of high quality teaching, and a host hospital for cutting edge research and innovation. On this we work in partnership with Brighton and Sussex Medical School, Health Education England, Kent, Surrey and Sussex Postgraduate Deanery and the Universities of Brighton and Sussex.

Purpose of the Quality Account

A Quality Account is a report to the public from providers of NHS Healthcare Services about the quality and standard of services they provide. Every Acute NHS Trust is required by the Government to publish a Quality Account annually. They are an important way for Trusts to show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

Ten Facts about the Trust

1. There is currently a £485 million redevelopment of the Brighton campus underway which will offer state of the art clinical facilities to patients in more than 30 wards and departments
2. The trust was taken out of Quality Special Measures by NHS Improvement in January following a Care Quality Commission inspection which rated the trust as Good overall and Outstanding for Caring
3. We had more than 4,000 patients volunteering to take part in one of the clinical research projects being conducted at our hospitals in Brighton and Haywards Heath
4. We completed a world surgical first with the introduction of an innovative new technique used by the cardiology team to clear blocked heart valves without the need for open heart surgery
5. Our Orthopaedic Team was the first in the UK to use a pioneering new implant during surgery which will dramatically improve recovery and rehabilitation time from fractures
6. We held our first ever LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) conference at the trust
7. We were ranked in the top 15% of hospitals in the entire country by the National Diabetes Audit
8. We achieved Hyper-Acute Stroke Unit status, which means we can now provide a full seven day service for these patients
9. Our Emergency Ambulatory Care Unit was one of the first units in the country to combine medical and surgical teams to treat emergency patients who don't need to stay overnight
10. Our maternity wards scored 10/10 against a strict set of national safety criteria

Statement on Quality from the Chief Executive Officer

Welcome to the 2018/2019 Quality Account from Brighton & Sussex University Hospitals. This document will review our progress over the last twelve months and look forward to the next year.

I am hugely proud to be part of this organisation, working with colleagues determined to further improve the services we provide. This dedication has led to some significant achievements in the past year, most notably the findings of our recent Care Quality Commission inspection, carried out in September.

In their report, published in January, inspectors rated the trust as 'Good' overall and 'Outstanding' for Caring, recognising the "huge improvements" made at the trust since its last inspection in 2016. As a result, BSUH was formally removed from quality special measures and following its emergence from financial special measures in July 2018 this completed one of the fastest and most significant transformation achieved by any NHS organisation.

Staff across the trust worked incredibly hard to achieve this improvement and I am pleased that the results of these efforts have been recognised by the CQC. The inspectors went away with a clear understanding that care is the organisation's top priority and front-line staff are empowered to make change themselves and are highly engaged and motivated.

Our Patient First programme is central to this progress, equipping staff to make improvements in line with our organisational priorities, something we describe as our True North. We have continued to roll the programme out during the year, with more than 35 areas completed by the end of March and a further 26 due to complete by the end of July.

At a corporate level, we completed our work with the Good Governance Institute to ensure clear lines of sight from the front line of service delivery through to board level on quality and safety. Our internal auditors have since provided the organisation with significant assurance as to the design and effectiveness of our quality management groups – recognition that we are able to identify and resolve issues much earlier, contributing to the improvements in patient care

While there has been significant progress, we aren't at the end of our improvement journey. Our Patient First approach, combined with the hard-work and dedication of our staff means I am confident that this will continue through 2019 and beyond.

The information contained within the Quality Account is, to the best of my knowledge, accurate.

Dame Marianne Griffiths – Chief Executive

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

2.1 Priorities for improvement in 2019/20

Quality can be defined in a number of ways but one well accepted definition is that for a service to be of high quality it should be safe, effective, patient centred, timely, efficient and equitable. Quality can be seen in education and training, staff morale, in research and development, and the exporting of knowledge and skills to the wider health economy. The Darzi Report (2008) found that quality should include the following aspects:

- Patient safety. The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive medication errors, rates of healthcare associated infections, falls, pressure ulcers etc.
- Patient experience. Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. This can only be improved by analysing and understanding patient satisfaction from their own experiences.
- Effectiveness of care. This means understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Just as important is the effectiveness of care from the patient's own perspective which will be measured through patient-reported outcomes measures (PROMs). Examples include improvement in pain-free movement after a joint replacement, or returning to work after treatment for depression. Clinical effectiveness may also extend to people's well-being and ability to live independent lives.

Last Year's Report

BSUH has made significant progress in improving quality in the last three years moving from a CQC rating of Inadequate to Good. This has been supported through the establishment and roll out of the Patient First programme, improvements in harm-free care and delivering 7-day services, alongside the establishment of a quality governance assurance framework.

In last year's accounts the Trust set out its short, medium and long term objectives.

For patient experience our long-term objective is to achieve an overall Friends and Family test score in excess of 96%. Steady progress was made last year towards achieving this target with the inpatient score increasing from 92% to 94% over the period April 2018 to March 2019.

For staff, our long-term objective is to be within the top 20% for staff engagement in the NHS staff survey by 2023. Improvements were made in all nine engagement questions in the 2018 staff survey and our overall staff engagement score increased from 6.5 to 6.9. Our breakthrough objective for last year was to increase the percentage of staff who believe that care is this organisation's top priority, we achieved this by increasing our score by 9% thus matching the national acute trust average.

Overall for the 2018 staff survey we were one of the most improved Trusts nationally as we showed a significant improvement in scores for 80 out of 90 survey questions when compared to 2017.

For quality improvement the Trusts long-term objective is to be in the top 20% of NHS Trusts for hospital standardised mortality ratio (HSMR) (the ratio of actual deaths to expected deaths). In the 12 months to January 2019 the Trusts HSMR was 96.55, meaning that the number of patients dying in the Trust was 3.45% lower than expected. This performance places the Trust in the top 30% for HSMR.

On systems and partnerships the true north objective is to have 95% of A&E patients waiting less than four hours to be admitted or discharged; and to reduce our referral to treatment time to below 18 weeks for 92% of patients. In 2018-19 the Trust experienced substantial challenges with delivering this target, although significant improvement has been made in eliminating those patients waiting 52 weeks or more. In 2019/20 the Trust will focus in on an improvement in performance against significant clinical pathways and planned transformational work, including the redesign of the Emergency Department, improvements in expediting discharge, a review of community bed usage, outpatient transformation and improvements in the delivery of endoscopy services.

Going Forward
Patient safety and quality happens in the moment, in the choices doctors and nurses make, in the compassion they exercise and, more than anything else, in their belief that doing the right thing is the only true north.

Healthcare is a highly regulated environment, but patient safety lies more in the invisibility of known but unproven indices, clinical outcomes and professional culture. It is poor communication, bullying, active covering up, inadequate leadership, ineffective team working, racism, lack of respect, intolerance, selfishness and a culture of fear that conspire to taint attitudes and behaviours and result in an unsafe and harmful environment that everyone 'sees' but no-one talks about. For the first time this year's Quality Accounts includes reports from the Trust's Freedom to Speak Up Guardian and the Guardian of Safe Working Hours.

Patient Safety
Our safety priorities are underpinned by two drivers – frequency of incidents reported and severity of incidents reported on the Trusts Incident Reporting system (Datix).

Despite a reduction of 48% in the rate of inpatient falls since 2010 falls continue to be one of the most frequently reported incidents. The reduction of avoidable falls will continue as a priority.

New national guidance on the management and reporting of pressure ulcers, along with increasing numbers of patients presenting with pressure ulcers or developing them has made the reduction and elimination of severe pressure ulcers a priority in 2019-20.

Although numerically venous thromboembolism (VTE) is not as frequently reported on Datix, three serious incidents in the past 18 months has commanded that the management and monitoring of this condition be made a priority for the Trust in 2019/20.

Patient Experience
In response to external partners and as a consequence of the most recent national patient experience survey, two new initiatives have been proposed in 2019-20. These are

- Frequent attenders in the Emergency Department – High intensity users service
- Improving hospital discharge planning project

Further information on patient experience and the work within the Trust can be found within the Trust's Annual Report.

Effectiveness of care

Three effectiveness projects will continue in 2019-20. These include the projects on sepsis and acute kidney injury (AKI), which are two of the projects that make up our improving care under the deteriorating patient programme umbrella. The reducing mortality programme of work will also continue under the supervision of the Trust Wide Mortality Review Group (TMRG)

Three new projects will commence this year, these are

- Improving the quality of care of people at the end of life
- Reduction in surgical site infections
- Trauma outcomes

All 13 initiatives will report regularly to the Patient Safety Group, the Clinical Outcomes and Effectiveness Group or the Patient Experience Panel. The Board will be updated on progress via the monthly Safety and Quality Report.

2.2 Statements of Assurance from the Board

Relevant Health Services and Income

During 2018/19 Brighton and Sussex University Hospitals NHS Trust provided a wide spectrum of acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, NHS England and other commissioning organisations to the value of £524m. Service delivery was underpinned by the regular monitoring of metrics reflecting patient safety, clinical effectiveness and patient experience.

Participation in clinical audits and confidential enquiries

During 2018/19 52 national clinical audits and 5 national confidential enquiries covered relevant health services that Brighton & Sussex University Hospitals NHS Trust provides.

During that period Brighton & Sussex University Hospitals NHS Trust participated in 96% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals NHS Trust was eligible to participate in during 2018/19 are as follows:

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The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals NHS Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audits	Eligible	Participated	Percentage submitted
Seven Day Hospital Services	Yes	Yes	100%
National Mortality Case Record Review Programme	Yes	Yes	12.5%
Adult Cardiac Surgery	Yes	Yes	100%
Adult Community Acquired Pneumonia	Yes	Yes	Ongoing
BAUS Urology Audit - Cystectomy	Yes	Yes	Ongoing
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Yes	Ongoing
BAUS Urology Audit - Nephrectomy	Yes	Yes	Ongoing
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	Yes	100%
Case Mix Programme (CMP)	Yes	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	Yes	95%

National clinical audits	Eligible	Participated	Percentage submitted
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes	100%
Feverish Children (care in emergency departments)	Yes	Yes	100%
Inflammatory Bowel Disease programme / IBD Registry	Yes	Yes	Ongoing
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%
Major Trauma Audit	Yes	Yes	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%
National Asthma and COPD Audit Programme	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People	Yes	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	Yes	Ongoing
National Audit of Care at the End of Life (NACEL)	Yes	Yes	100%
National Audit of Dementia	Yes	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Yes	Ongoing
National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	Ongoing
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	No	N/A
National Comparative Audit of Blood Transfusion Programme	Yes	Yes	100%
National Congenital Heart Disease (CHD) (Adult services only)	Yes	Yes	100%
National Diabetes Audit – Adults	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	61%

National clinical audits	Eligible	Participated	Percentage submitted
National Heart Failure Audit	Yes	Yes	100%
National Joint Registry (NJR)	Yes	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
National Oesophago-Gastric Cancer (NAOGC)	Yes	Yes	51-60%
National Ophthalmology Audit	Yes	No	N/A
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Vascular Registry	Yes	Yes	95-99%
Neurosurgical National Audit Programme	Yes	Yes	100%
Non-Invasive Ventilation – Adults	Yes	Yes	Ongoing
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	>90%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	100%
Surgical Site Infection Surveillance Service	Yes	Yes	100%
UK Cystic Fibrosis Registry	Yes	Yes	100%
Vital Signs in Adults (care in emergency departments)	Yes	Yes	100%
VTE Risk in Lower Limb Immobilisation (care in emergency departments)	Yes	Yes	100%

National confidential enquiries	Eligible	Participated	Percentage submitted
Cancer in Children, Teens and Young Adults	Yes	Yes	100%
Perioperative Diabetes	Yes	Yes	76%
Pulmonary Embolism	Yes	Yes	100%
Acute Bowel Obstruction	Yes	Yes	Ongoing
Long Term Ventilation	Yes	Yes	Ongoing
Perinatal Mortality Surveillance (reports annually)	Yes	Yes	100%
Perinatal Morbidity and Mortality Confidential Enquiries (reports alternate years)	Yes	Yes	100%
Maternal Mortality Surveillance and Mortality Confidential Enquiries (reports annually)	Yes	Yes	100%
Maternal Morbidity Confidential Enquiries (reports annually)	Yes	Yes	100%

The reports of 20 national clinical audits were reviewed by the provider in 2018/19 and Brighton & Sussex University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Title	Action taken or planned
Cardiac Rhythm Management	Performance against the audit's quality standards are reviewed at the cardiac governance meetings and all recommendations from the latest national report are currently being met.
National Hip Fracture Database	Our results continue to be very good; our mortality rate last year was approximately half the national average at 30 days. We are also making ongoing improvements in time to theatre with 85.9% of patients are getting to theatre in less than 36 hours. The quality of care is continuously reviewed at the multidisciplinary clinical governance meetings and through the Patient First Improvement System initiatives.
Myocardial Ischaemia National Audit Project (MINAP)	The call-to-balloon and door-to-balloon times are reviewed for every individual case to ensure that the national targets are being achieved. Specific delays to treatment are discussed and investigated where appropriate.
National Audit of Breast Cancer in Older People	We participate in the breast screening national data audit and contribute quality assurance data on the breast screening service. Due to lack of mammographers, we are currently failing on the screening round length (but regular review and an action plan is in place). We are also participating in the implant breast reconstruction evaluation (iBRA) study of breast implant surgery and its complications. We are in the upper quartile for low infections rates and loss of implants.

Title	Action taken or planned
National Heart Failure Audit	With the established role of a full-time Heart Failure Specialist Nurse at Princess Royal Hospital (PRH) and a consultant lead two days a week we continue to see an improvement in our audit scores. We are also working towards an industry-funded 2 year nurse specialist role at PRH to help with the increased numbers of patients attending. We also now have a full time colleague who is present one day each week at PRH and four days a week at Royal Sussex County Hospital (RSCH) on the Acute Ambulatory floor.
National Neonatal Audit Programme (NNAP)	Our performance against all the audit standards, including admission temperature, is now at or above the UK mean. We continue to monitor admission temperatures closely and work continues to reduce term admissions.
Neurosurgical National Audit Programme	We are taking part in the National Acoustic Neuroma Audit, where all acoustic neuroma patients presenting to the skull base service are included.
VTE Risk in Lower Limb Immobilisation (care in emergency departments)	The audit showed that there was no routine recording of a patient information leaflet about VTE risk and symptoms being given to patients with temporary limb immobilisation. Emergency department staff will therefore review the information currently given to patients and ensure an up to date leaflet is available in the department.
Adult Cardiac Surgery	Outcomes data is presented regularly to the Cardiac Surgery Clinical Governance and Management meetings, and the department maintains a record of all deaths following cardiac surgery, which are reviewed and action points documented.
Case Mix Programme (CMP)	Quarterly benchmarking reports are circulated and reviewed regularly amongst the critical care directorate. The clinical lead presents the data at the Quality Patient Safety Experience meetings.
Major Trauma Audit	The development and use of a bespoke trauma database continues and is being used across the relevant teams, thus improving data quality and timely submission to the Trauma Audit and Research Network (TARN). Trauma pathways and outcomes have been identified as a quality improvement initiative so a project is now underway to prioritise this. We now have additional staff members in the Trauma Practitioners Team providing extra cover and liaising closely with TARN coordinators.
National Audit of Care at the End of Life (NACEL)	The Trust has introduced the following initiatives; an updated care plan; symptom control documentation; and enhanced education around essential conversations and decision making. These improvements will be measured by a rolling audit of case notes, a patient experience survey of bereaved carers, and the triangulation of data around admissions, incidents and Medical Emergency Calls.

Title	Action taken or planned
National Audit of Percutaneous Coronary Interventions (PCI)	All patients undergoing PCI are entered onto a dedicated database following their procedure. The Consultant operator activity and outcome data are published online and these data sets are available for public review.
National Congenital Heart Disease (CHD)	All eligible cases are uploaded to the National Institute for Cardiovascular Outcomes Research (NICOR) database and a sample is audited by a dedicated team at NICOR to validate the data.
National Oesophago-gastric Cancer (NAOGC)	Case ascertainment has been low due to longstanding problems with uploading data from our local systems on to the national database. Department staff are currently exploring alternative methods to improve our uptake rate in the future.
National Vascular Registry	The Trust's outcomes are reviewed regularly, and any missing data is sought and subsequently included in the registry.
UK Parkinson's Disease Audit	The annual review of documentation has now been amended to include additional enquiries regarding patients' condition, symptoms and information received. The clinic check-in process has also been amended to include an opportunity for signposting to social assistance and patient/carer groups.
Elective Surgery (National PROMs Programme)	We have introduced additional patient education around washing and dressing after hip and knee replacements. This is in response to some low scoring around these issues in the post-operative questionnaires.
National Emergency Laparotomy Audit (NELA)	The latest published report showed that case ascertainment is still low, however an audit officer has now been put in post to raise case ascertainment and the data available from 2018 shows a marked improvement in data capture. With the advent of the best practice tariff there are now regular improvement meetings being held to discuss data from the audit. As a result, there have been improved outcomes in consultant presence at surgery and appropriate critical care as needed. A new clinical pathway has been implemented in line with best practice outcomes from the audit.
National Audit of Dementia: Spotlight Audit of Delirium	To improve the assessing and recording of people with delirium, single clerking, which is already in place at one of our hospital sites, is to be rolled out to the other site in the near future. This includes the Single Question in Delirium (SQiD) question. In addition, training in dementia is available to all staff, and higher level more focused dementia training has been made available to staff working on elderly care and dementia wards.

The reports of 20 local clinical audits were reviewed by the provider in 2018/19 and Brighton & Sussex University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Specialty	Project Title	Actions to improve the quality of care
Interventional Radiology (IR)	Average Interventional Radiology Waiting Times for Emergency Vascular Admissions	As a result of this audit a fully functional IR rota has been implemented. This has resulted in decreased waiting times which has in turn lowered the length and cost of the patient hospital stay and resulted in earlier discharge from hospital.
Emergency Department (ED)	Royal Sussex County Hospital Chaperone Policy in the Emergency Department	As a result of this audit posters will be displayed in our ED waiting and clinical areas to address the Care Quality Commission (CQC) concerns that patients may not be being made aware of their right to a chaperone when being examined. The audit will be repeated after this intervention to investigate for a statistically significant change in the number of patients who report being aware of this policy.
Digestive Diseases	Surgical E-Discharge Summary	Guidance has been developed and displayed at various locations within the department to minimise variability in the information provided in the 'To Take Out' form which is completed for all patients being discharged from hospital.
Anaesthetics	Anaesthetic Documentation at Arrest Calls and Rapid Sequence Inductions (a method of achieving rapid control of the airway whilst minimising the risk of regurgitation and aspiration of gastric contents)..	The results of this audit showed that the most senior anaesthetist was not documented on 30% of occasions. A recommendation was made suggesting a brief teaching session to be given to junior anaesthetists regarding the importance of careful documentation of the responsible anaesthetic consultant, and any discussions had with the senior. A further recommendation was that patient details for all Anaesthetic Support Calls (ASCs) should be documented via switchboard to aid further audit of ASCs and whether or not they are recorded on Bamboo (the Trusts Information Technology platform). A re-audit in 3 months' time was suggested.

Specialty	Project Title	Actions to improve the quality of care
Trauma & Orthopaedics / Neuro radiology /Neurosurgery	Screening for Blunt Vertebral Vascular Injury	The results of this audit recommended the need to develop a local protocol for screening and for further engagement with the Emergency Medicine and Trauma Team. To re-audit after the establishment of a local protocol.
Neurosurgery	Use of Antithrombotic Medications in Elective Neurosurgical Patients	In order to reduce complications the audit suggested updating the clerking proforma to ensure patients admitted on antithrombotic medication are identified at admission, alongside indication and stop date. And amending the ward round proforma to include prompts in regards to anticoagulation intended restart dates.
Acute Medicine / Respiratory Medicine / Cardiology	Emergency Oxygen Prescribing	This audit found that whilst oxygen saturations are documented on 100% of observational rounds, improvements are required in the signing for of oxygen on drug rounds. Further awareness and training for both doctors and nursing staff on the importance of the need for correct prescription of oxygen is suggested as well as a re-audit to include further wards and assess any improvements in oxygen prescribing.
Neonatology	National HIV and Syphilis Surveillance	This is an ongoing audit with continuous data collection. BSUH are the top antenatal screening centre in the UK.
Neonatology	Avoiding Term Admissions Into Neonatal units (ATAIN)	The audit and subsequent actions have resulted in a reduction in admissions to the neonatal unit.
Anaesthetics and Pain Management	Preloading with Gabapentin and Enhanced Recovery for Laparoscopic Nephrectomy	Preliminary data suggests that preloading with Gabapentin may reduce post-operative opioid requirements, pain controlled analgesia use and length of hospital stay. New departmental pain guidelines were developed for laparoscopic nephrectomy which suggest preloading with Gabapentin to take advantage of its opioid sparing effects. These results will be shared at a number of relevant speciality committees including anaesthetics and urology.

Specialty	Project Title	Actions to improve the quality of care
Pain Management	Pain Controlled Analgesia (PCA) Chart Documentation Audit	The audit demonstrated a remarkable improvement in documentation of all fields of the PCA form, meaning that patients are receiving safer care when prescribed intravenous opioids via PCA. Considerations for the next audit - completion of "hourly pump check" was not commented on in this audit. We must ensure this is audited next time as it is a key component of the observation chart and is required by the policy. Actions include; continue collecting audit data annually; continue to review the PCA chart and discuss changes with the Multi-Disciplinary Team; review the policy at the next annual review date (2019); highlight any successes and issues identified by audit in teaching sessions.
Emergency Department	Spontaneous Pneumothorax in Adults	A formalised local policy on follow up to help avoid unplanned re-attendance and ensure uniform management and safe follow up was proposed. Respiratory physicians have agreed that follow up should be in the pleural clinic via the Emergency Ambulatory Care Unit. An easily accessible patient information leaflet is required, improved coding and there is also the potential for prompt cards to include a pneumothorax flow chart outlining management principles and follow up procedures.
Endocrinology & Diabetes	Endocrinology & Diabetes Patient Satisfaction Survey	In general the patient feedback received was positive, however it did highlight that patients require further information regarding free prescriptions.
Dermatology	Teledermatology Pilot Audit	Analysis of the pilot phase of this audit allowed the setting up of the new rapid access lesion pathway that aims to reduce the number of benign lesions seen in clinic and increase clinic availability for non-skin lesion dermatology. Two melanomas were picked up in patients that were not referred under the 2 week wait cancer pathway who would have previously waited longer for treatment under the non-urgent clinic waiting times.

Specialty	Project Title	Actions to improve the quality of care
Trauma & Orthopaedics	Functional Outcomes & Weight Bearing Status of Stable Weber B Ankle Fractures	The departmental protocol for the management of stable Weber B fractures was finalised and functional outcomes checked and parallelised with the national standards.
Anaesthetics	Improve Patient Experience of Learning Disability Patients Requiring Sedation for Investigations and Procedures	The findings were quite variable and highlighted lengthy waiting times. Successful interventions were achieved in multiple clinical areas. Data collection to explore waiting times over time was proposed.
Paediatric Surgery	Paediatric Surgery Appendicitis Audit	Stricter adherence to protocol is required otherwise an improvement was seen in negative appendicectomy and post-operative collection rates.
Anaesthetics / Neurosurgery	Blood Sugar Monitoring in Patients on Dexamethasone	Adherence to the Joint British Diabetes Societies national guidelines was found to improve following additional education. A re-audit is planned to ensure that this improvement is sustained.
Microbiology / Infectious diseases	Management of Acute Bacterial Meningitis	Actions planned following this audit include; discuss ideas with acute services; education of microID services to improve recommendation for HIV testing; changes to the microguide to include samples to be sent; review of the lumbar puncture proforma with an additional sheet on specific meningitis information; education at foundation level and registrar level on meningitis guidelines.
Digestive Diseases	Lower Gastro-Intestinal Bleeding (LGIB)	A teaching session to ensure all senior house officers and foundation year 1 doctors are aware of the national guidelines for LGIB has been proposed. As has the development of a flowchart for the recommended management of LGIBs to be posted on the Intranet.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Brighton and Sussex University Hospitals NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 4056.

Goals agreed with Commissioners: Use of the Commissioning for Quality and Innovation Payment Framework

A proportion of Brighton & Sussex University Hospitals NHS Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Brighton & Sussex University Hospitals NHS Trust's and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Statements from the Care Quality Commissioner (CQC)

Brighton and Sussex University Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Brighton and Sussex University Hospitals NHS Trust during 2018/19.

Brighton and Sussex University Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

NHS Number and General Medical Practice Code Validity

Brighton and Sussex University Hospitals NHS Trust submitted records during 2018/19 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (April 2018 to January 2019):

Which included the patient's valid NHS number was:

99.2% for admitted patient care:

99.6% for outpatient care and

95.2% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

99.9% for admitted patient care;

100% for outpatient care; and

99.1% for accident and emergency care.

Data Security and Protection Toolkit Attainment Levels

Brighton and Sussex University Hospitals NHS Trust has submitted its Data Security and Protection Toolkit Assessment Report for 2018/19, demonstrating Information Governance and Information Security compliance. The overall outcome was 'standards not met'. This is as a result of five of the forty requirements not being fully met.

NHS Digital, which manages the Toolkit, allows Trusts to provide an improvement plan setting out the steps which will be taken to meet the standards in full within six months of submission. This plan has been agreed by the Trust's Senior Information Risk Owner. Once NHS Digital has approved it, the published outcome will be changed to 'standards not fully met (plan agreed)'.

Clinical Coding Error Rate

Brighton & Sussex University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2018-19 by the Audit Commission.

Data Quality

Brighton & Sussex University Hospitals NHS Trust will be taking the following actions to improve data quality:

- Internal training: The Trust has created an online training course on patient identification and promotes this course regularly to all staff. The Corporate Data Team has implemented the process of giving staff and team's feedback on data quality process errors, mistakes and NHS Digital best practice.
- Internal data quality reporting: The Corporate Data Team is implementing a data quality monitoring and reporting suite which covers the main aspects of data quality in the Trust such as coding, Master Patient Index, admitted patient care, reference data and more. Once implemented, it will be actively promoted to all data collection areas and data owners.
- National data quality reporting: The Corporate Data Team is looking to produce an action plan to address our weaker data quality items as identified within the national data quality indicator reports.

Learning from Deaths

Deaths in 2018/19

During 2018 /19 1641 of the Brighton & Sussex University Hospitals NHS Trust patients died (of which 36 were neonatal deaths/stillbirths, 13 were people with learning disabilities and 4 had a severe mental illness). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 376 in the first quarter (of which 10 were neonatal deaths/stillbirths, 1 were people with learning disabilities and 0 had a severe mental illness).
- 349 in the second quarter (of which 7 were neonatal deaths/stillbirths, 2 were people with learning disabilities and 0 had a severe mental illness).
- 434 in the third quarter (of which 12 were neonatal deaths/stillbirths, 6 were people with learning disabilities and 2 had a severe mental illness).
- 482 in the fourth quarter (of which 7 were neonatal deaths/stillbirths, 4 were people with learning disabilities and 2 had a severe mental illness).

Mortality Reviews

31 March 2019, 197 case record reviews and 3 investigations have been carried out in relation to 238 of the deaths.

In 1 case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 63 in the first quarter;
- 62 in the second quarter;
- 35 in the third quarter;
- 38 in the fourth quarter.

Patient deaths judged to be more likely than not to have been due to problems in the care provided to the patient

2 representing 0.1% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 0.3% for the first quarter;
- 0 representing 0% for the second quarter;
- 1 representing 0.2% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using root cause analysis to conduct a full serious incident investigation.

Investigations into 4 deaths in the reporting period remain ongoing at the time of writing.

Learning from case record reviews and investigations

Learning from case record reviews and investigations conducted in relation to the deaths identified:

- Commercially available electronic (e) prescribing software with the functionality to prevent the prescription of drugs to patients with known allergies would likely have prevented this incident.
- The absence of a red wrist band is not sufficient to exclude the presence of an allergy.
- Nursing staff would benefit from further support for managing the deteriorating sepsis patient.
- A standardised nursing handover process between the Emergency Department and wards is essential to ensure care of patients is optimised.
- A Trust-wide electronic process to alert clinical staff if medication has been omitted would remove the risks associated with relying on staff to detect this whilst working in extremely busy environments.

Action following our learning

Actions taken and proposed to take as a result of learning identified:

- Implementation of an e-Prescribing software package
- Review of the 'red allergy wrist band' guidance to ensure the process is robust and fit for purpose.
- A quality improvement plan is in progress, as part of the Trust's work towards the national CQUIN for "Reducing the impact of serious infections: Antimicrobial Resistance and Sepsis" within secondary care. Specific wards are being targeted where the prevalence of sepsis is higher to support nursing staff in the recognition and evaluation of the deteriorating sepsis patient.
- The Emergency Department is in the process of introducing revised, more user-friendly Safety Nursing documentation. The booklet includes the new Trust telephone handover checklist using the 'Situation, Background, Assessment, Recommendation' (SBAR) framework. The SBAR handover form is also being rolled out for use across the organisation.

The impact of our actions

The evaluation of these actions is currently being incorporated into the specialty quality improvement programmes for 2019/20.

Mortality reviews relating to deaths during the previous reporting period

10 case record reviews and 6 investigations completed after 1 April 2018 which related to deaths which took place before the start of the reporting period.

Patient deaths judged to be more likely than not to have been due to problems in care during the previous reporting period

6 representing 0.4% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using root cause analysis to conduct a full serious incident investigation.

Revised estimate of deaths judged to be more likely than not to have been due to problems in care during the previous reporting period

11 representing 0.7% of the patient deaths during 2018-19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Implementing the Priority Clinical Standards for 7 Day Services

Brighton and Sussex University Hospitals Trust has made good progress in implementing the four priority clinical standards and is expected to fulfil the seven day service standards for all admitting specialities by 2020.

Performance in the most recent 7 day services survey, undertaken in spring 2018 is detailed in the table below:

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 2: Time to 1st Consultant Review	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard met

This represents an improvement in performance when compared to the autumn 2017 survey from 76% to 91%, for patients admitted as an emergency, receiving a thorough clinical assessment by a suitable consultant within 14 hours of admission to hospital.

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 5: Access to Diagnostics			
Microbiology	Yes available on site	Yes available on site	Standard met
Computerised Tomography (CT)	Yes available on site	Yes available on site	
Ultrasound	Yes available on site	Yes available on site	
Echocardiography	Yes available on site	Yes available on site	
Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
Upper GI endoscopy	Yes available on site	Yes available on site	

There is no change from the spring 2017 survey where all diagnostic tests were noted to be available on site.

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 6:Consultant Directed Interventions			
Critical Care	Yes available on site	Yes available on site	Standard met
Interventional Radiology	Yes available on site	Yes available off site via formal arrangement	
Interventional Endoscopy	Yes available on site	Yes available on site	
Emergency Surgery	Yes available on site	Yes available on site	
Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
Urgent Radiotherapy	Yes available on site	Yes available on site	
Stroke Thrombolysis	Yes available on site	Yes available on site	
Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
Cardiac Pacing	Yes available on site	Yes available on site	

There is no change from the spring 2017 survey where all consultant directed interventions were noted to be available on site or offsite via formal arrangement.

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 8:Ongoing Daily Consultant Reviews			
Once daily review	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard not met
Twice daily review	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

This represents an improvement in overall performance when compared to the spring 2017 survey from 95% to 100% for patients receiving twice daily reviews. The performance for once daily review has decreased from 91% to 88%, however further interrogation of the data has identified that 'board rounds' were not included as a consultant review. If the consultant 'board rounds' had been included BSUH would most likely have achieved this standard.

Staff Who Speak Out

Staff members have a number of channels available to them to speak up about issues or concerns they have, particularly those relating to quality of care, patient safety, and bullying or harassment. Brighton and Sussex University Hospital NHS Trust is implementing a Patient First Strategy across the organisation, which is based on a localised version of the Virginia Mason Production System (a methodology designed to transform health care). The objective of the strategy is to embed and sustain a culture of continuous improvement. The Trust is actively inviting staff to speak up and contribute to discussions and activities to improve both patient and staff experience.

Brighton and Sussex University Hospital NHS Trust is promoting a culture which encourages staff to speak up. In the first instance, all staff are directed towards their line manager/supervisor/team leader. In addition, staff have access to a listening and support service called Connections; the support of staff networks; and a Diversity and Inclusion Team.

The Trust employs a Freedom to Speak Up Guardian whose role is to support staff who, for whatever reason, are struggling to speak up or get action, or having spoken up are subsequently concerned about the impact it has had on them. Where staff are concerned about possible detrimental effects of speaking up, the Freedom to Speak Up Guardian supports them to do so in confidence and also ensures outcomes and feedback are shared with them.

Additionally, the Freedom to Speak Up Guardian promotes speaking up in the Trust by talking to groups and teams, for example at staff inductions. In addition to this the Freedom to Speak Up Guardian works collaboratively with staff from Patient Safety and Human Resources, and routinely reports to the Trust Board.

Rota Gaps and Plans for Improvement

The Guardian of Safe Working Hours engages closely and regularly with trainee doctors across the organisation to identify and escalate any areas of concern relating to training, supervision and workload. These are then systematically reported to the Medical Director through regular meetings, and to the Trust Board through quarterly exception reports. This active monitoring enables issues related to the training and pastoral care of junior doctors to be actively monitored as per the requirements of the 2016 Junior Doctor Contract.

For example, during 2018, challenges to training and service delivery in the medical specialties at Princess Royal Hospital as a result of workforce shortages were reported by the Guardian of Safe Working Hours. The Trust responded with an immediate expansion of the senior decision making workforce at Princess Royal Hospital. Specific steps included:

- The recruitment of a Chief Registrar, two Clinical Fellow posts and two Locum Consultants at Princess Royal Hospital, thus augmenting both junior and senior grade presence on the hospital floor.
- A significant investment in the substantive senior medical workforce at Princess Royal Hospital was made, both to improve medical team resilience by increasing 'hands on' consultant support to trainee doctors and to reduced junior 'doctor to patient' ratios by providing an additional consultant-led team.
- The refurbishment of on-call rooms to provide dedicated modern, fit for purpose rest facilities for junior doctors from all specialties.

All safety concerns raised by junior medical staff, either through Datix (the Trust's incident reporting system) or verbally, now undergo prompt investigation under the direction of a Consultant Specialty Lead, and are reported through existing Divisional Governance channels to the Patient Safety Quality Management Group by exception.

In response to the Guardian of Safe Working Hours concerns, regular meetings between the Medicine Division and trainees now enable rota solutions to be 'jointly owned' and have resulted in a number of innovative developments including:

- A 'WhatsApp' alert system for shift vacancies
- Increased Bank registration and promotion
- Indicative rotas being pre-circulated so trainees can 'pre-populate' leave requests as far as possible.

A clear standard operating procedure for managing both predictable and short notice rota vacancies is embedded in all specialities. This is coordinated and supervised daily by the Divisional Rota Management Teams with support from the relevant Chief of Service and Divisional Director of Operations. The importance of active leave management is reinforced by the Divisional Chiefs and Postgraduate Education Training Leads.

2.3 Reporting Against Core Indicators

Since 2012/13 NHS Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. These core indicators align closely with the NHS Outcomes Framework (NHSOF).

The majority of core indicators are reported by financial year, e.g. from 1st April 2018 to 31st March 2019, however some indicators report on a calendar year or partial year basis. Where indicators are report on a non-financial year time period this is stated in the data table. It is important to note that some national data sets report in significant arrears and therefore not all data presented are available to the end of the current reporting period (31st March 2019).

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 died following hospitalisation 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. The SHMI gives an indication for each non-specialist acute NHS trust in England on whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

Indicator **Domain**	Summary Hospital-level Mortality Indicator Preventing people from dying prematurely				
2018	National average	Best performing Trust	Worst performing Trust	2017	2016
97.94% ***As expected***	100% ***As expected***	68.88% ***Lower than expected***	120.59% ***Higher than expected***	98.93% ***As expected***	98.70% ***As expected***
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

Table based on latest available data (January - December 18)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons, it is taken from a well-established national source.

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by routinely monitoring mortality rates at the Trust Mortality Review Group (TMRG). This monitoring includes looking at mortality rates by specialty, diagnosis and procedure. A systematic approach is adopted whenever an early warning of a problem is detected. This work is supported by our Coding Department to ensure any clinical and non-clinical concerns are identified.

Palliative care indicators are included below to assist in the interpretation of SHMI by providing a summary of the varying levels of palliative care coding across non-specialist acute providers.

Indicator Domain	Percentage of patient deaths with palliative care coded at either diagnosis or specialty level Preventing people from dying prematurely				
BSUH 2018	National average	Highest Trust	Lowest Trust	BSUH 2017	BSUH 2016
1.82%	1.76%	3.34%	0.78%	1.17%	1.29%
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

Table based on latest available data (January - December 18)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reason, it is taken from a well-established national source.

The Brighton and Sussex University Hospitals NHS Trust intends to take the following actions to improve this percentage and so the quality of its services, by regular monitoring at the Trust Mortality Review Group.

Patient Reported Outcome Measures

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) Hip replacement surgery;
(ii) Knee replacement surgery.

PROMs for groin hernia repair and varicose vein surgery were discontinued as part of the mandatory national PROMs programme in October 2017, and are therefore no longer reported on.

National reporting timeframes have changed during 2018/19. The most recently published adjusted health gain figures available are finalised data, covering the period 2017/18. Comparable provisional data for 2018/19 will become available in summer 2019. Below are the adjusted average health gain figures for the EQ5D outcome measures.

Indicator Domain	Patient Reported Outcome Measures EQ 5D Index (casemix adjusted health gain) Helping people to recover from episodes of ill health or following injury					
Type of Surgery	BSUH	National average	Best performing Trust	Worst performing Trust	201/18	2016/17
Hip replacement	0.439	0.458	0.539	0.407	0.399	0.434
Knee replacement	0.317	0.337	0.367	0.292	0.284	0.302
Data Source	http://www.hscic.gov.uk/proms					

Latest available data (2017/18, finalised data published Feb 2019)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons; it has been taken from a national data set and the Trust's participation rate is high, meaning that the data are reliable.

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Reviewing the 'Washing and dressing' PROMS scores that were not where we wanted them to be. We have investigated this, and put more patient education into washing and dressing;
- Continuing to analyse the PROMs scores data and feeding this back to clinical teams.

Patients readmitted to a hospital

The percentage of patients aged:

- 0 to 17; and
- 18 or over

readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Indicator **Domain**	Crude Readmission Rate for patients readmitted to a hospital within 30 days of being discharged Helping people to recover from episodes of ill health or following injury					
Age Group	BSUH	National average	Best performing Trust	Worst performing Trust	2017	2016
Patients aged 0 to 17 years	11.7%	12.7	0.0%	42.8%	11.8%	12.9%
Patients aged >18 years	14.9%	14.5%	2.6%	27.4%	14.7%	13.8%
Data Source	Standardised Readmission Ratio produced using Healthcare Evaluation Database					

Table based on latest available data (January - December 18)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reason it is taken from a national provider.

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to work closely with commissioners to identify patients at risk of readmission. When individual groups of patients are identified action is taken to reduce the likelihood of the patient being readmitted. The Trust routinely monitors this data for accuracy.

Responsiveness to the personal needs of patients

This indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Indicator Domain	Responsiveness to the personal needs of patients Ensuring people have a positive experience of care				
2018/19	National average	Best performing Trust	Worst performing Trust	2016/17	2015/16
67.8%	68.6%	85.0%	60.5%	67.4%	68.7%
Data Source	NHS Digital https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs				

Table based on latest available data (2018)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons it is produced by the Picker Institute in accordance with strict criteria.

The Brighton and Sussex University Hospitals NHS Trust intends to take the following actions to improve this percentage and so the quality of its services, by developing an action plan that addresses the issues raised in the National Patient Survey which will focus on improvements in food and drinks rounds, privacy and dignity, discharge planning and information 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:

Indicator Domain	Percentage of staff who would recommend the Trust as a provider of care to their family or friends Ensuring people have a positive experience of care				
2018	National average	Best performing Trust	Worst performing Trust	2017	2016
67.7%	71.3%	87.3%	39.8	57.9%	54.6%
Data Source	NHS Digital http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RXH_full.pdf				

Table based on latest available data (2018)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons we have developed a systematic approach to the collection of the Friends and Family Test (FFT) scores.

The Brighton and Sussex University Hospitals NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to

focus on staff engagement as part of the Leadership, Culture & Workforce programme with the overall aim of improving staff engagement across the Trust. We have a True North objective to be in the top 20% of NHS employers in future staff survey results.

Patients who would recommend the trust to their family or friends

Patients who use A&E or Inpatient areas are asked a single question about whether they would recommend the NHS service they have received to friends and family who need similar treatment.

Indicator **Domain**	Percentage of patients who would recommend the Trust as a provider of care to their family or friends Ensuring people have a positive experience of care				
2018-19	National average	Best performing Trust	Worst performing Trust	2017-18	2016-17
93.3%	95.6%	100.0%	71.4	95.3%	96.2
Data Source	NHS England				

Table based on latest available data (February to January 2019)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons. In 2018/19 The Trust changed to an electronic collection system for the Friends and Family Test (FFT) survey, by surveying patients outside of the hospital setting we expected to see a lower percentage of patients recommending. The benefit to using this system is that we have seen our response rate rise from 11% to 26% meaning we are able to hear the voice of more of our patients.

The Brighton and Sussex University Hospitals NHS Trust intends to take the following actions to improve this percentage and so the quality of its services, by using data received from the FFT survey and other patient experience data to drive improvement work in line with the trust's true north objective of achieving 96% of inpatients who would recommend the trust to their family and friends.

Patients admitted to hospital who were risk assessed for VTE

This indicator looks at the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

Indicator **Domain**	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism Treating and caring for people in a safe environment and protecting them from avoidable harm				
BSUH 2018-19	National average	Best performing Trust	Worst performing Trust	BSUH 2017	BSUH 2016
92.6%	95.5%	99.4%	74.4%	93.14	90.03
Data Source	NHS Digital https://improvement.nhs.uk/resources/vte-risk-assessment-data-q1-201819/				

Table based on latest available data (Quarter 1, 2 and 3 for 2018-19)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons it is taken from a national data source and the data is routinely scrutinised in the monthly Safety and Quality Report produced for the Board

The Brighton and Sussex University Hospitals NHS Trust intends to take the following actions to improve this percentage and so the quality of its services, by the purchase of an electronic prescribing system which would enable better data recording of this rate and act as a prompt to undertake a risk assessment.

Rate of *C.difficile* infection

The rate per 100,000 bed days of cases of *C. difficile* infection reported within the trust amongst patients aged 2 or over during the reporting period.

Indicator	The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the Trust amongst patients aged 2 or over	
Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm	
	2017-18	2018-19
BSUH rate	19.0	16.1
National average	13.7	-
Other Trusts – Best Performing	0.0	-
Other Trusts – Worst Performing	91.0	-
Data Source	National data for 2018/19 is not available at the time of publication	

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons every case is scrutinised using a Root Cause Analysis (RCA) process to determine whether the case was linked with a lapse in the quality of care provided to patients.

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by systematically undertaking RCA reviews into every case.

Patient safety incidents and the percentage that resulted in severe harm or death

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

i) rate of incidents reported per 1000 bed days
ii) rate of incidents that resulted in severe harm or death per 1000 bed days
iii) number of incidents resulting in severe harm or death
iv) % of Severe Harm or Death over number of reported incidents.

Indicator	Patient safety incidents and the percentage that resulted in severe harm or death							
Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm							
	October 16 to September 17				October 17 to September 18			
	(i)	(ii)	(iii)	(iv)	(i)	(ii)	(iii)	(iv)
BSUH	36.63	0.09	27	0.25	38.95	0.07	20	0.17
Average	41.36	0.15	37	0.36	43.07	0.15	36	0.34
Best*	82.25	0.01	2	0.02	115.83	0.01	2	0.04
Worst	23.41	0.54	207	1.72	23.09	0.46	138	1.26
Data Source	NHS Improvement https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019/							

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons. The data is derived from the National Reporting and Learning System for patient safety incidents and a panel of consultants reviews this data weekly in order to ensure every incident is correctly graded in accordance with guidance issued by the National Patient Safety Agency.

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by continually encouraging and making it easier for staff to report incidents, as a consequence the number of incidents reported has risen by 12% during 2018-19 from 10,713 to 11,981.

Additional note requested by auditors * There is no 'correct' or 'safe' number of patient safety incidents: a 'low' reporting rate should not be interpreted as a 'safe' organisation, and may represent under-reporting; a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may represent a culture of greater openness. It is generally regarded as better to have a high rate and for this reason we have assigned the tag of best to the highest reporting rate

Part 3: Other Information relevant to the quality of care.

3.1 Other Quality Information

Patient Safety

Elimination of severe pressure ulcers *(new project)*

Pressure ulcers are caused when an area of skin and the tissues below it are damaged, as a result of being placed under pressure sufficient enough to impair its blood supply.

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility or impaired nutrition. Also, the use of equipment such as seating or beds which are not specifically designed to provide pressure relief can cause pressure ulcers.

A recent National Institute for Health Research (NIHR) funded programme of study found that patients reported pressure ulcer pain as their most distressing symptom, and pain at pressure areas was experienced prior to pressure ulcer manifestation, and that patient's reports of pain were ignored by nurses. The study also found that severe pressure ulcers were more likely to develop in contexts where clinicians failed to listen to patients/carers or recognise/respond to high risk or the presence of an existing pressure ulcer, and also in services which were not effectively co-ordinated.

On an average day in Brighton and Sussex University Hospitals NHS Trust, 111 beds (12% of the bed stock) are occupied by a patient who has generated a pressure ulcer or wound care referral. This group of patients accounted for 40,018 bed stay days in the last financial year, with an average length of stay of 21.4 days.

Based on comparative length of stay data this cohort of patients potentially had an excess bed stay of 15% (6,138 excess bed days).

The National Institute for Health and Care Excellence (NICE) notes that significant savings could be made by reducing the number of people who develop pressure ulcers, as treating them involves a longer and more costly hospital stay. The estimated cost of treatment for this cohort of patients is £6m in 2017-18. £1.2m for acquired pressure ulcer damage and £4.8m for patients admitted with pressure ulcers.

Target	By when (date)
The rate of newly acquired pressure ulcers was 1.05 per 1000 bed stay days in 2018-19.The target for the next financial year is a reduction of 10% or a rate of 0.945 per 1000 bed stay days	April 2020
In 2018-19, 13 patients acquired a grade 3 or 4 pressure ulcer. For 2019-20 we have set a target of no more than 10.	April 2020
In 2017-18, 74% of the pressure ulcers reported occurred in the community. The final objective for the next financial year is to establish a forum with Sussex Community NHS Foundation Trust to explore areas of collaborative working.	April 2020

Falls prevention *(new project)*

Patient falls are ubiquitous; in 2009-10 over 1,400 falls were reported at Brighton and Sussex University Hospitals NHS Trust. Their frequency makes them the norm not the exception, and in being the norm, they can appear to be part of a patient's journey to rehabilitation, or part of their deterioration into frailty.

Since 2009-10, the Falls Prevention Programme has reduced the rate of falls in BSUH by 48% and has sustained this improvement over 5 years. To date, it's estimated that the project has prevented over 4200 inpatient falls. In 2017 NHS Improvement published 'The Incidence and costs of inpatient falls in hospital', this document estimated that the average cost of an inpatient falls was £2600 as a result of potentially prolonged hospital stay, diagnostic and surgical and non-surgical interventions. Based on this estimate the falls project has produced a saving in excess of £11m.

Target	By when (date)
Maintain the 2018-19 rate of 3.38 falls per 1000 bed stay days.	April 2020
Achieve the CQUIN target of 80% of all older inpatients receiving key falls prevention actions	April 2020

Improving the Care of Patients with Venous Thromboembolism *(new project)*

Venous thromboembolism (VTE) is a leading cause of death and disability in the UK. It is a condition in which a blood clot forms, most often in the deep veins of the leg, groin or arm (known as a deep vein thrombosis or DVT) and travels in the circulation, lodging in the lungs (known as a pulmonary embolism or PE).

In the past 18 months, the Trust has conducted three serious incident investigations into the management of patients with a VTE. This initiative is designed to undertake a baseline assessment of current performance and improve the governance arrangements for reporting hospital associated VTE.

The same day emergency care treatment of PE's is also a CQUIN this year; improved same day treatment will reduce pressures on hospital beds, improve length of stay and improve patient experience.

Target	By when (date)
Undertake a Structured Judgement Review (SJR) into all pulmonary embolism deaths post discharge in 2019/20.	April 2020
Improvement in the 2018-19 Root Cause Analysis rate (53.6%) for hospital acquired VTE	April 2020
Improvement in the 2018-19 rate of avoidable hospital acquired VTE (2.3%).	April 2020
Review the VTE related emergency readmissions data in order to develop a plan to reduce this to lower than the national average. In 2018-19 the Trust rate was 0.11%	April 2020
Meet the CQUIN target of 50 – 75% of eligible patients to be managed in a same day setting for PE's.	April 2020

Effectiveness

Improving care for the deteriorating patient – Sepsis

Sepsis, a syndrome of physiologic, pathologic, and biochemical abnormalities induced by infection, is a major public health concern, accounting for more than 47,000 deaths in the UK in 2017. Problems in achieving consistent recognition and rapid treatment are thought to contribute to the number of preventable deaths from sepsis every year.

The objectives set in 2018/19 for this initiative were partially achieved:

- Roll out the new amended version of the National Early Warning Score (NEWS) 2.0.
- Develop a Trust Policy for Blood Cultures[1]

Our 2018-2019 Sepsis improvement work has continued to focus on the early recognition and prompt escalation of patients who present to the Emergency Department (ED), or deteriorate on the wards as an inpatient. A screening tool is now being used in both environments, providing structured guidance to ensure quick diagnosis of sepsis and rapid administration of treatment.

National requirements, outlined in the CQUIN framework, aim to embed a systematic approach for prompt identification and appropriate treatment of life-threatening infection. Last year's requirements have been partially met, with the Trust fully achieving the sepsis screening of all patients, and 90% of Emergency Department patients receiving antibiotics within 1 hour of sepsis diagnosis. For inpatients, of the sample audited, 58% of patients received IV antibiotics within 1 hour of diagnosis. There is, therefore, a need to identify and evaluate individual practices at ward level. The aim of this is to improve the recognition and evaluation of the deteriorating sepsis patient, and to consider how to improve compliance with the sepsis screening tool and treatment, enhance staff experience and lead to better patient outcomes.

There are approximately 52 adult wards throughout the Trust, all of which are provided with sepsis awareness and education by the Sepsis Clinical Nurse Specialist (CNS). With huge variation in prevalence of sepsis and equivalent variation in demand within the role, there is a need to breakdown the wards, with a focus on those that care for the most acutely unwell patients. Data has been triangulated to identify the wards that have a high prevalence of both sepsis and medical emergencies, and to propose a focussed sepsis improvement plan for these wards. Efforts are now focussed primarily on 10 key wards, with an enhanced auditing process adapted from retrospective (current system) to concurrent, live data collection. This should provide the benefit of:

- Data collected 'closer' to the teams, who are more empowered towards improving quality
- Sepsis CNS able to have a 'hands-on' education role and consistent feedback on good practice and lessons learned.
- Better alignment to the Patient First 'Deteriorating Patient Breakthrough objective' for quality.

The updated version of the National Early Warning system (NEWS2) has been implemented across the Trust. This scoring system allows early identification of the deteriorating patient

[1] A Blood Culture is a test designed to detect if microorganisms such as bacteria and fungi are present in blood.

by using a simple aggregate, in which a score is allocated to the six physiological parameters we measure when monitoring patients (e.g. blood pressure, heart rate). The importance of considering serious sepsis in patients with known or suspected infection, or at risk of infection, is emphasised on the new documentation. A NEWS score of 5 or more is the key threshold for urgent clinical review and action. This will encourage prompt recognition and escalation of the sepsis patient and part of the clinical response will be to complete a sepsis screen and obtain a senior doctor review.

This initiative will continue in 2019/20 and will be monitored through the refreshed Deteriorating Patient Programme.

From April 2019, an electronic patient observations system will be introduced to the Trust. This system will dramatically change the way we capture vital signs and clinical data by moving from a paper-based to an electronic system. In other organisations, this has shown to improve patient safety and care by planning and performing patient observations, assessments and clinical documentation at the bedside, thereby ensuring the early detection of, and timely clinical response to deteriorating patients including sepsis. The sepsis screening tool will also be embedded into the system, ensuring 100% screening is achieved and prompting staff to consider sepsis in every patient scoring NEWS 5 or more.

Target	By when (date)
100% of patients screened for sepsis (who met the screening criteria).	April 2020
90% of antibiotics given within one hour of diagnosis.	April 2020

Improving care for the deteriorating patient – Acute Kidney Injury

When your kidneys stop working suddenly, over a very short period of time (usually two days or less), it is called acute kidney injury (AKI). AKI is usually diagnosed with a blood test to measure your levels of creatinine, a chemical waste product produced by the muscles. If there's a lot of creatinine in your blood, it means your kidneys are not working as well as they should. The severity of AKI is described by categorising it into three stages, with stage 1 being the least severe and stage 3 being the most severe.

AKI is very serious and requires immediate treatment. It normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell with other conditions and the kidneys are also affected.

It's essential that AKI is detected early and treated promptly. Without quick treatment, abnormal levels of salts and chemicals can build up in the body, which affects the ability of other organs to work properly. If the kidneys shut down completely, this may require temporary support from a dialysis machine, or lead to death

In 2018/19 the objectives for this initiative were to improve recognition of acute kidney injury (AKI) by:

- Testing AKI IT changes
- Testing our capacity to receive & act on AKI warning results

- Trial of ICE (the Trusts pathology reporting software) and PANDA (the Trusts clinical portal) AKI infrastructural changes at a ward level
- Continue the AKI audit
- Refine AKI data visualisation
- Improve response after an AKI diagnosis
- Explore overlap with other priorities, such as NEWs monitoring, sepsis, fluid prescribing,
- Continue evaluation of the AKI checklist
- Review AKI social media identity

The aims set in 2018-9 were partially achieved. Further changes in passive alerts in AKI IT resources have delayed matters but several additional services have trialled these resources without significant problems being identified. The roll out of ICE OrderComms (a system that allows diagnostic tests and treatment services to be ordered instantly, eliminating delays, bottlenecks and errors of paper-based) will mean that going forward all new users will have access to AKI warning test results. BSUH now submits AKI warning test results to the UK Renal Registry which means that the ICE-based BSUH bespoke application of the AKI national algorithm can be evaluated. Interruptive alerting needs to be progressed. Small scale tests of change are being designed with the Critical Care Outreach Team and Pharmacy with volunteers sought amongst junior medical staff to further test check lists and Human Factors AKI interface

This initiative will continue in 2019/20 with:

- A progressive roll-out (via PANDA OrderComms) of AKI warning test results,
- Teaching junior staff (all groups) about existing AKI resources and support.
- The integration of the recognition of kidney deterioration alongside the recognition of physiological deterioration.
- The further development of a robust strategy for measuring improvement.
- The engagement of clinicians to develop and test change ideas for their patients to deliver
    - recognition of those at risk of AKI
    - recognition of AKI once present
    - interventions to improve outcomes

Target	By when (date)
Deliver interruptive alerts to acute trust and primary care for AKI 1 and 2 with hyperkalaemia and all AKI 3	April 2020
Engage with the BSUH Kaizen (continuous improvement) Team as sponsors for ward/departmental implementation	April 2020
Critical Care Outreach Team deployment of AKI tools and resources	April 2020
Deployment of AKI medication review in specialist and medical divisions	April 2020

Reduction in surgical site infections (new project)

A surgical site infection (SSI) is an infection that occurs after surgery in the part of the body where the surgery took place. SSI's can sometimes be superficial infections involving the skin only. Others are more serious and can involve tissue under the skin, organs, or implanted material.

Currently the Trust is mandated to undertake surveillance of SSI's for four orthopaedic procedures. This initiative is aimed at expanding the scope of the surveillance programme in collaboration with the National 'Getting it Right First Time' (GIFT) programme. It has been designed to undertake a baseline assessment of current Trust performance and improve the governance arrangements for reporting SSI's. In addition, antibiotic surgical prophylaxis in colorectal surgery is a new national CQUIN for 2019/20. The aim of the CQUIN is to ensure the appropriate use of preventative antibiotics in elective colorectal surgery.

Target	By when (date)
Identify the surgical site infection rates of specific procedures within key surgical specialties.	April 2020
Achieve the CQUIN target of 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines	April 2020

Reducing mortality

There are approximately 1600 deaths occurring in BSUH every year. For many people, death under the care of the NHS is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of reviewing deaths is to identify areas for improvement so we can learn and provide better care for future patients.

This initiative is designed to implement the National Learning from Deaths Guidance and BSUH Learning from Deaths Policy, and to establish improved governance structures around mortality reviews.

The aim of this work in 2018/19 was the further implementation and embedding of the National Guidance on Learning from Deaths and also to be at the forefront of the national Medical Examiner programme.

Reflecting on progress, the Trust has achieved the stated aims. After 1st April 2019, a National Medical Examiner (ME) programme for in-hospital deaths will be implemented. BSUH were part of a pilot to introduce Medical Examiners, this service is currently established at the Royal Sussex County Hospital. Eight new Medical Examiners have recently been appointed bringing the total number to ten at the RSCH. Work is ongoing to expand the service to the Princess Royal Hospital in 2019/20.

Governance processes have been strengthened, the Trust Mortality Review Group reports to the Patient Safety Committee, which in turn reports to the Quality Governance Steering Group.

BSUH have rolled out an in house training programme to support initial training provided by the Royal College of Physicians. Nine training sessions have been delivered in 18/19 across both the RSCH and PRH to a variety of clinicians, nurses, core medical trainees and allied

health care professionals. In total 62 staff have been trained to undertake structured judgement reviews (SJRs).

The SJR forms have been embedded into the Trust wide on-line clinical information system, the Panda application, to facilitate data collection and analysis.

The current bereavement families/carers questionnaire has been reviewed and a new shorter questionnaire has been developed and implemented.

In March 2019, the CQC published 'A review of the first year of NHS trusts implementing the national guidance'. The review identified five factors to help trusts put the guidance into practice:

- values and behaviours that encourage engagement with families and carers
- clear and consistent leadership
- a positive, open and learning culture
- staff with resources, training and support
- positive working relationships with other organisations

The aims for 19/20 will be to focus on strengthening practice in the areas identified by the CQC and furthermore to:

- increase the focus on the themes for learning from SJR
- appoint a Lead Medical Examiner to expand the Medical Examiner programme to the PRH
- increase administrative support to increase the % of patients undergoing SJR
- embed the SJR methodology into the departmental Mortality and Morbidity meetings

Target	By when (date)
Increase the proportion of SJRs undertaken in 2019-20 from 12.47% in 2018-19	April 2020
Increase the proportion of SJRs reporting positive scores in 2019-20 for 'Overall Assessment' score from 56% in 2018-19	April 2020
Decrease the proportion of SJRs reporting problems in care in 2019-20 from 40% in 2018-19	April 2020

Improving the quality of care of people at the end of life (new project)

The 2018 National Audit of Care at the End of Life (NACEL) focussed on the quality and outcomes of care experienced by those in their last hospital admission throughout England and Wales.

Professor Bee Wee, the National Clinical Director for End of Life Care, stated that "this important National Clinical Audit will shine a light on the care that dying people receive in acute, community and mental health hospitals. We need to work hard to constantly improve the experience of people at the end of their lives, as well as those who matter the most to them. I would strongly encourage all trusts to participate."

Brighton and Sussex University Hospitals Trust participated in this audit, which monitored progress against the five priorities for care as set out in the 'One Chance to Get It Right' report and in NICE Quality Standards around the last year of life. These priorities included recognising and communicating about dying; sensitive communication; involvement in decisions around care; meeting the needs of loved ones; and ensuring an individualised care plan.

The Trust are continuing with quality improvement work in end of life care, and since the national clinical audit have introduced a number of improvements including; an updated care plan and symptom control documentation, enhanced education around best practice, essential conversations and decision making, and making and documenting individualised care plans.

Continued improvements will be measured (and informed) by a process of case note audit, bereaved carer's survey responses, and the triangulation of admissions, incident and Medical Emergency Call (MET) data. Quality improvement initiatives will be refined to improve the care and experiences of patients and those identified as important to them.

The aim of these initiatives is to:

- Improve the quality of care for people at the end of life in acute, mental health and community hospitals.
- Increase the opportunity to identify those patients who may benefit from a treatment escalation plan (TEP), and to ensure that the wishes of patients and those around them are taken into account. This plan may include a palliative and supportive approach, advance care planning and handover of key information between healthcare providers (which may reduce unwanted readmission and avoidable harm.)

Target	By when (date)
Increase the number of patients with a treatment escalation plan: 75% of patients leaving the Acute Floor (discharged or moved to a specialty ward) to have a TEP documented.	April 2020
All clinical areas to have the new Trust TEP guidance and education plan established.	April 2020
Embed the process of improving and measuring the 5 priorities of care. Data from the following sources to be triangulated to inform the improvement process: • Rolling case note audit • Responses to the bereaved carer's survey • Percentage of patients with a TEP documented	April 2020

Trauma Outcomes (new project)

In 2012, the Royal Sussex County Hospital was designated as the regional Major Trauma Centre for Sussex, providing 24/7 enhanced specialist care for the most seriously injured patients within the Sussex region.

In 2019 two critical steps in the development of the Trauma Centre will take place with the establishment of a new trauma ward and opening of the Helideck.

The aim of this initiative is to ensure that the governance arrangements in trauma develop at the same pace as the clinical developments, so that patients and the Trust Board can be assured that the Trauma Centre is achieving the best possible clinical patient outcomes and that any lapses in care are quickly identified and rectified.

Target	By when (date)
Establish a scrutiny panel to review the clinical management of every 'code red' patient (i.e. a patient with clinical evidence of significant traumatic haemorrhagic shock)	April 2020
Systematically undertake a Structured Judgement Review (SJR) into every trauma death.	April 2020
Develop a trauma outcomes scorecard combing data from Trauma and Audit Research Network (TARN) with information collated from clinical incidents, complaints and Healthcare Evaluation Data (HEDs; the national benchmarking database)	April 2020
Establish a monthly Trauma Governance Meeting to: • Progress multi-disciplinary collaborative working • Discuss the findings from the scrutiny panel • Review the outcome from the Structured Judgement Reviews (SJR's) • Scrutinise the trauma scorecard • Refine clinical pathways based on the findings from the SJRs and scrutiny panel • Update the Board monthly via the monthly Quality Board report	April 2020
Introduce and start using the code red structured clinical review tool	May 2019

Patient Experience

Improving Hospital Discharge Planning Project (new project)

There are multiple challenges facing the NHS at this time and the recent winter season demonstrated areas of strengths within the organisation but also highlighted some real areas requiring improving. Following the latest Patient Survey and Healthwatch report, feedback received indicates that improvements in early communication and information received by patients within the first 48 hours of admission would benefit patient experience, manage expectations and potentially reduce length of stay in hospital.

To achieve this one of the areas which requires improvement is the flow of patients through the organisation, from admission to discharge. A delay in the patients flow through the hospital can result in acutely unwell patients not being placed in the right place at the right time. The evidence suggests that this can, unfortunately, create an unsafe care environment for these patients.

It is well known that there are many benefits to patients being discharged effectively from the hospital setting to the community setting including; a reduction in hospital acquired infection, optimised rehabilitation, and improved patient experience. Improving hospital discharge planning would in turn increase patient flow through the acute bed base resulting in acutely

unwell patients being placed in the right place at the right time, creating a safer environment for patients throughout their hospital journey

Target	By when (date)
To see a 25% reduction in complaints relating to hospital discharge	April 2020
To see a 25% reduction in safeguarding alerts relating to hospital discharge	April 2020
Reducing the number of patients with a length of stay of over 21 days by 40%'	April 2020
To see a 25% increase in discharges before 12 midday	April 2020
To see a decrease in the number of patient safety incidents in relation to discharge. In 2018-19, 34 discharge planning incidents were submitted and 23 were submitted in relation to inadequate discharge information.	April 2020

Frequent Attenders in the Emergency Department – High Intensity Users Service (*new project*)

Frequent Attenders make up a significant percentage of all attendances. Consistent findings from cohort studies show that 'frequent attenders' to Accident and Emergency (A&E) Departments tend also to be frequent users of other health and social care facilities. Additionally, they tend to have a higher triage category, greater rates of admission, and a greater burden of chronic disease, when compared to matched groups[2]

Between 2017 and 2019, BSUH have been collaborating on a project (CQUIN) to improve services for people with mental health needs who present to A&E. This project has involved mental health and acute hospital providers working together with other partners to ensure that people presenting at A&E with primary or secondary mental health/underlying psychosocial needs have these needs met more effectively, through an improved, integrated community service offer, with the result that attendances at A&E for two cohorts of patients have been reduced.

Following on from this, BSUH are implementing the High Intensity Users service*, which will broaden the impact of the work of the CQUIN, and apply a multi-agency approach to frequent users to A&E (with any diagnosis). Regular meetings are taking place, attended by a number of inter-agency partners (including Sussex Partnership Foundation Trust, Sussex Community Foundation Trust, Mental Health Liaison Team, Learning Disability, speciality teams, Pavilions and homeless organisations) who meet to discuss and improve care plans for the top 70 users of the BSUH Emergency Department (between November 2017 and October 2018). The work is nationally and locally supported, with case study resources. The view would be to introduce a commissioned service in order to improve patient care pathways, meet any identified unmet need, and reduce the burden on services with a personalised and patient focussed approach.

*The High Intensity User (HIU) service (first launched in Blackpool) offers a robust way of reducing frequent user activity primarily to A&E and non-elective admissions but can also contribute to reducing other avoidable unscheduled care contacts.

[2] Frequent Attenders in the Emergency Department – Best Practice Guideline – The Royal College of Emergency Medicine - August 2017

Target	By when (date)
Arrange at least quarterly meetings of the High Intensity Users Multi-Disciplinary Team	April 2020
Review the needs of patients identified, and in collaboration with relevant agencies, generate enhanced care plans for these patients.	April 2020
Reduce attendances for the top 70 users of the Emergency Department (between November 2017 and October 2018) by 20%	April 2020

3.2 Performance against the relevant indicators and performance thresholds

BSUH aims to meet all national targets and priorities. All Trusts report performance to NHS Improvement (NHSI) against a limited set of national measures of access and outcome to facilitate assessment of their governance. As part of this Quality Account, we are advised to report on the following national indictors.

Performance against the NHS Improvement Single Oversight Framework	2018/19 (Apr 18 – Mar 19)	NHS Improvement threshold 2018/19	2017/18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	73.66%	92%	83.12%
A&E: maximum waiting time of 4hours from arrival to admission/ transfer/ discharge	83.10%	95%	84.28%
All cancers: 62-day wait for first treatment from:			
a) urgent GP referral for suspected cancer	71.25%	85%	76.6%
b) NHS Cancer Screening Service referral	68.25%	90%	69.6%
C. difficile: variance from plan	Reported in 2.3 core indicators		
Summary Hospital-level Mortality Indicator (also included in quality accounts regulations)	Reported in 2.3 core indicators		
Maximum 6-week wait for diagnostic procedures	20.12%	1%	**6.06%**
Venous thromboembolism (VTE) risk assessment	Reported in 2.3 core indicators		

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Sussex and East Surry Clinical Commissioning Groups

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 community priorities.

There are notable improvements evident from the national staff survey results in relation to staff engagement and their experience of working in the Trust - an increase from 58% 'recommending the Trust as a place to work' in 2017 to 68% in 2018.

A collaborative approach with other providers is noted and welcomed within this quality account in relation to reduction of avoidable pressure damage. The CCG hopes this collaborative approach could be extended in 2019/20 and beyond to learning from incidences of infections (such as C.Diff and E.Coli) occurring both within the hospital and community to support improved health outcomes across the whole health economy.

The report places a significant emphasis on learning, such as from complaints or from reviews of deaths, which is welcomed and indicative of an organisation that is striving for continual quality improvement. The CCG has a responsibility to scrutinise serious incidents from providers, and it is of note that BSUH generally provides high quality investigation reports to the CCG, and the CCG will continue to work with the Trust to ensure that learning and actions from serious incidents are embedded within the organisation.

The CCG is in agreement with the new quality improvement projects identified for 2019/20. It welcomes the inclusion of a dedicated project to improve hospital discharge as it recognises the negative impact that can occur for people when this is not optimised, and successful implementation should lead to measurable improved patient experience. It also welcomes a focus on A&E attenders given pressures reported during the year within the Emergency Department.

In relation to constitutional standards (reported in Section 3.2 of the report) the CCG is aware the Trust is not meeting some key performance standards at time of writing. The CCG is aware of challenges in ensuring there is sufficient workforce in all areas and specialities that can impact on performance, which is also experienced by other providers. In addition to supporting the Trust to finding solutions to improve performance, the CCG will continue to seek assurance on the impact on patients where constitutional standards are not being met.

Overall the CCG has seen evidence of significant quality improvements being made within the Trust in 2017/18, illustrated by a new 'good' rating by the Care Quality Commission, and the CCG looks forward to working with the Trust to make further improvements in 2019/20. The commissioners are therefore pleased to endorse this quality account and we look forward to continuing an effective working relationship so we can all drive forward improvements for our local populations

Healthwatch Brighton and Hove

Healthwatch Brighton and Hove have continued to work closely over the last year with BSUH to help improve quality of patient care. We have provided monthly visits to wards by our volunteers and made dozens of practical suggestions for improving the patient experience. BSUH have acted on most of our recommendations and progress is tracked and checked. Healthwatch have also carried our patient experience reviews of the Emergency Departments for Adults and Children at the Royal County Sussex Hospital and co-operated with other local Healthwatch in a similar review involving the Princess Royal Hospital.

Healthwatch recently carried out a review of hospital discharge and community follow up for Older Frail people. This has resulted in a joint action plan from BSUH and Brighton and Hove Adult Social Care to address the issues raised, including improvements in personalised care and better information for patients, friends and families.

We are delighted that in the last year BSUH has secured a satisfactory CQC Care Quality Commission report and has been able to exit special measures.

Annex 2 – Statement of Directors' responsibilities for the Quality Account

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 Quality Governance Steering Group 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. By order of the Board

Dame Marianne Griffiths – Chief Executive   Alan McCarthy- Chairman,

Annex 3 – Limited Assurance Report on Quality

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

This report is produced in accordance with the terms of our engagement letter dated for the purpose of reporting to the Directors of Brighton and Sussex University Hospitals NHS Trust (the 'Trust') in connection with the Quality Account for the year ended 31 March 2019 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 26 March 2019. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 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 permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our examination, for this report, or for the opinions we have formed.

Our work has been undertaken so that we might report to the Directors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

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, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations
2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

• Rate of clostridium difficile infections.

• 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 Ernst & Young LLP

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care 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; and
- the Quality Account has been prepared in accordance with Department of Health and Social Care 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 accordance with section 8 of the Health Act 2009 and the criteria set out in the National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("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 published on the NHS website in March 2015 ("the Guidance"); and
- 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 the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15'. These are:

- Board minutes for the period April 2018 to June 2019;
- papers relating to quality reported to the Board over the period April 2018 to June 2019;
- feedback from the Commissioners dated 2/05/2019;
- feedback from Local Healthwatch dated 2/05/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 25/07/2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2019;

- the annual governance statement dated 28/05/2019;
- the Care Quality Commission's Inspection report(s) dated 08/01/2019; and
- the results of the Payment by Results coding review dated September 2018

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.

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

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included, but were not limited to:

- 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.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Account. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent 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 and Social Care. 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.

Basis for qualified conclusion

Percentage of patient safety incidents resulting in severe harm or death

The Trust is unable to reconcile data relevant to the indicator held on its local Datix system and data submitted to the National Reporting and Learning System (NRLS) that is actually used to calculate the published indicator. We are therefore unable to confirm that data we have substantively tested on the Datix system in support of the indicator is consistent with that actually used to produce the indicator. We have quantified the difference in the indicator calculated based on the Datix system data compared to the published result based on the NRLS data. The NRLS data shows significantly worse performance than had the Datix system data been used to calculate the published indicator.

As a result of this we are unable to conclude the published indicator result is accurate, valid, reliable, timely or complete.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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; an
- 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.

Suresh Patel
Associate Partner
For and on behalf of Ernst & Young LLP
Southampton

26 June 2019

Glossary of terms and acronyms

Care Quality Commission (CQC) An independent regulator responsible for monitoring and performance measuring all health and social care services in England.

Clinical Audit The process by which clinical staff measure how well the Trust performs against agreed standards. Action plans for improvement are often based on the findings of an audit.

Clinical Pathways The standardisation of care practices to reduce variability and improve outcomes for patients.

Clostridium Difficile (C.Diff) A form of bacteria that is present naturally in the gut of around 2/3s of children and 3% of adults. On their own they are harmless, but under the presence of some antibiotics they will multiply and produce toxins (poisons) which cause illness such as diarrhoea and fever. At this point, a person is said to be infected with C. difficile.

Commissioning for Quality and Innovation (CQUIN) The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care.

Darzi Report Lord Darzi's 2008 review concludes a series of reports, consultations and recommendations for a ten year vision for a world class National Health Service (NHS) that is fair, personal, effective and safe.

Friends and Family Test (FFT) The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Governance The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and wider community.

Healthwatch Healthwatch England is the independent consumer champion for health and social care in England.

Information Governance (IG) Information Governance allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

IG Toolkit The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information, Governance policies and standards. It also allows members of the public to view information of participating organisations.

Major Trauma Centre (MTC) A network of 22 new centres throughout the UK, specialising in treating patients who suffer from major trauma.

Mortality Review A process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care and identify learning, plans for improvement and pathway redesign where required.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) NCEPOD assists in maintaining and improving standards of healthcare for adults and children by reviewing the management of patients and by undertaking confidential surveys and research.

National Early Warning Score (NEWS) NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. NEWS2 is the updated version of this tool.

National Institute for Health and Clinical Excellence (NICE) The National Institute for Health and Clinical Excellence provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

National Reporting and Learning System (NRLS) The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Clinicians and safety experts help analyse these reports to identify common risks and opportunities to improve patient safety.

Overview and Scrutiny Committee (OSC) Local authority bodies that provide scrutiny of health provision in their local area.

Root Cause Analysis (RCA) RCA is a process designed for use in investigating and categorising the root causes of events. When incidents happen, it is important that lessons are learned across the NHS to prevent the same incident occurring elsewhere. RCA investigation is a well-recognised way of doing this.

Safeguarding Processes and systems for the protection of vulnerable adults, children and young people.

'Situation, Background, Assessment, Recommendation' SBAR Tool is an easy to use, structured form of communication that enables information to be transferred accurately between individuals. SBAR was originally developed by the United States military for communication on nuclear submarines, but has been successfully used in many different healthcare settings, particularly relating to improving patient safety

Serious Incidents (SIs) Something out of the ordinary or unexpected. It is an incident – or a series of incidents – that, if left unattended, may pose a risk to service users or the health and safety of staff, visitors and others.

Structured Judgement Mortality Review The SJR review methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.