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

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 Government to publish a Quality Account annually and are an important way 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

In 2016-17 the Trust:

1. Employed 8200 members of staff
2. Received the help of 457 volunteers who gave 1472 hours of their time per week
3. Delivered 5,585 babies
4. Saw 161,974 A&E patient attendances
5. Treated 55,087 patients for unplanned procedures and 14,902 patients for planned procedures.
6. Treated 50,378 patients as day cases
7. Cared for patients in 340 acute beds
8. Received 609 compliments and plaudits from patients and relatives
9. Had 2,338,000 hits on the public website from 473,300 unique users and 3250 Twitter followers
10. Received £1.7 million in donations through the BSUH Charity
Part 1

Statement on quality from the Chief Executive

Welcome to our 2016/17 Quality Account which reviews our performance on safety and quality and sets out our safety and quality priorities for 2017/18.

Part 3 sets out how we performed against a range of safety and quality indicators and describes the progress we made against the priorities we set ourselves for 2016/17.

In April 2016 CQC inspected the Trust and found significant failings. In June 2016 CQC issued a warning notice in respect of their findings and detailed the work the Trust was required to do to address them by the end of August 2016.

CQC published its inspection report in August 2016 in which the Trust was rated overall as ‘inadequate’. Following publication of the report, NHS Improvement placed the Trust in Special Measures.

The Trust Board agreed an Integrated Recovery Plan in September 2016 which set out the Plan to tackle our quality and financial failings. CQC revisited the Trust in January 2017 and found that no further enforcement action was required and that significant improvements had occurred in many areas. A full re-inspection of the Trust took place in April 2017 and the findings of the inspection will be addressed in 2017/18.

Part of our response to being placed in Special Measures has been to invest in the expertise and commitment of staff in improving quality through our Improvement Academy.

The Quality Account highlights some of the excellent work carried out by staff to date. We will build on this work further in the coming years, using the experience of the new Executive Team, who assumed responsibility for the leadership of the Trust from 1st April 2017, and the Patient First programme developed in Western Sussex Hospitals NHS Foundation Trust.

Although the Trust was placed in Special Measures in 2016/17, many staff, teams and services have continued to deliver excellent care for patients and this report also highlights the Best of BSUH.

Looking forward, we have also identified the projects described in Part 2 which are designed to improve patient safety and the experience of patients in 2017/18.

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

Marianne Griffiths
Chief Executive
Priorities for improvement in 2017/18

Following the Trust being placed in quality and financial special measures, and to provide leadership from an outstanding Trust, BSUH, Western Sussex Hospitals NHS Foundation Trust (WSH) and NHS Improvement made an agreement in March 2017 that the WSH leadership team, Executive and Non-Executive, would lead the Trust from 1st April 2017, for a period of 3 years.

This Agreement identified 5 key priorities:

- delivering the improvements necessary to enable BSUH to exit Financial Special Measures;
- delivering the improvements necessary to enable BSUH to exit Quality Special Measures;
- addressing the underlying issues at BSUH relating to leadership and culture which were inhibiting the delivery of improvements to services;
- effective implementation of a three year plan to improve accident and emergency performance; and
- effective oversight of the 3Ts Programme.

The Patient First programme drives quality improvement in BSUH. It comprises four strategic themes: sustainability; our people; quality improvement; and systems and partnerships; to enable excellent care for patients.
The Trust defined its *True North* targets in 2017/18, for each of the strategic themes:

### Patient

**Patient Satisfaction**  
**Friend & Family Test**  
*Current: Overall Score*  
IP = 96.9%  
A&E = 89.4%  
*Target: Overall Score >96%*

### Sustainability

**Budget Management**  
*Current: 17/18 plan*  
£65.4m deficit  
*Target: Achieve Break Even*

### People

**Staff Engagement**  
*Current: 16/17 Staff Survey = 3.62*  
*Target: Staff Engagement Score Top 20% in the Country*

### Quality

**Preventable Mortality**  
*Target: HSMR Top 20%*

**Avoidable Harm**  
*Target: Harm Free Care*

### Systems & Partnerships

**Non Elective Flow**  
*Current: 86.0%*  
*Target: A&E 95% <4hr*

**Elective Flow**  
*Current: 86.1%*  
*Target: RTT 92% <18wks*

For each of the strategic themes, breakthrough objectives were identified which represent significant improvement, and are clearly defined and measurable in relevant real time. These improvements were designed to have the biggest impact on achievement of the relevant True North.

The objectives are:

<table>
<thead>
<tr>
<th>True North Domain</th>
<th>Breakthrough Objective</th>
<th>Metric</th>
<th>Outcome</th>
<th>Executive Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Reduction in negative feedback where staff attitude is cited as an issue</td>
<td>Number of complaints relating to staff attitude</td>
<td>Increase in a recommendation rate in FFT</td>
<td>Nicola Ranger (Chief Nursing Officer)</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Achieve the Efficiency plan for 2017/18</td>
<td>3.4% Savings vs Planned Budget</td>
<td>Control Total for 2017/18 achieved</td>
<td>Karen Geoghegan (Chief Financial Officer)</td>
</tr>
<tr>
<td>People</td>
<td>Staff believe that Care is the top priority for the organisation</td>
<td>Increase in % staff agreeing “Care is the Top Priority”</td>
<td>Engaged staff measured through the Staff Survey results</td>
<td>Denise Farmer (Chief Workforce Officer)</td>
</tr>
<tr>
<td>Quality</td>
<td>Improvement in Sepsis recognition and timely response</td>
<td>Compliance against Sepsis six</td>
<td>Improvement in Sepsis related mortality</td>
<td>George Findlay (Chief Medical Officer)</td>
</tr>
<tr>
<td>Systems &amp; Partnerships</td>
<td>Reduction in the numbers of patients waiting &gt;4hrs in A&amp;E who are not admitted</td>
<td>75% decrease in the numbers of non-admitted breaches</td>
<td>Sustainably achieve &gt;90% A&amp;E 4hr target</td>
<td>Pete Landstrom (Chief Delivery Officer)</td>
</tr>
<tr>
<td>Systems &amp; Partnerships</td>
<td>Ensure no patients wait over 52 weeks for elective treatments</td>
<td>0 x 52 week RTT breaches</td>
<td>Reduction in harm and improvement in % 18wk RTT compliance</td>
<td>Pete Landstrom (Chief Delivery Officer)</td>
</tr>
</tbody>
</table>
Part 2

Improvement Academy

Launched in October 2016, the BSUH Improvement Academy aims to train and enable staff to identify process and working practices that can be improved and empowers them to make the necessary changes.

Led by the Director of Service Transformation and Deputy Medical Director, Safety and Quality, the team has now completed 5 intensive workshops each one focused on removing inefficiencies and improving the overall patient experience:

– Patient pathways in urgent care
– Imaging services for our inpatients
– Fractured neck of femur pathway
– Cataract pathway on day of surgery
– Endoscopy booking services

In each case we engaged our patients and the work was led by the clinical teams at the heart of each service. They worked together to identify changes that would improve the overall patient experience and the results are now starting to benefit our patients and make it easier for staff to do their jobs.

We are also working hard to ensure others can access the best of what improvement science has to offer and share and celebrate the improvements that follow. After an initial intensive training period for a small number of senior leaders, BSUH has developed a bespoke 2 day training programme. 50 staff completed this training during 2016/7 and that training is now running monthly. The team also offers tailored half day immersions for teams and bespoke coaching. This is supported by other BSUH colleagues, each with their own specialist areas of expertise who help deliver our bespoke 2 day training on a voluntary basis and support and mentor others.

Our info net page is now live and includes our first two improvement videos. Others are in production. This work will evolve further in 2017/18 as BSUH implements its Patient First programme.
Statements relating to quality of NHS services provided

Review of services

During 2016/17 Brighton & Sussex University Hospitals NHS Trust provided acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups and NHS England. £503m of our income came from Clinical Commissioning Groups and NHS England for patient care activity. The income generated by the NHS services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by Brighton and Sussex University Hospitals NHS Trust for 2016/17.

Each of our 12 Clinical Directorates and the specialties within them reviews the data available to them on the quality of care in their services. To support this we implemented a Safety and Quality dashboard for each of the Clinical Directorates containing standard information on patient safety, clinical effectiveness and patient experience.
Part 2

Participation in clinical audits and confidential enquiries

National clinical audits

During 2016/17, 43 national clinical audits and 6 national confidential enquiries covered NHS services that Brighton and Sussex University Hospital NHS Trust provides.

During that period Brighton and Sussex University Hospital NHS Trust participated in 91% of national clinical audits and 100% of the national clinical audits which it was eligible to participate in.

The national clinical audits that Brighton and Sussex University Hospitals NHS Trust participated in, and for which data collection was completed during 2016/17 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit.

Where the Trust did not participate in a national clinical audit, the reasons are also described below. This includes for example, the National Cardiac Arrest Audit (NCAA) where the national audit is less comprehensive than the local audit we have had in place for a number of years. The reports of the national clinical audits detailed below were reviewed by the provider in 2015/16 and Brighton and Sussex University Hospitals NHS Trust intends to take the actions described in this section of the report to improve the quality of healthcare provided.

The reports of 43 national clinical audits were reviewed by the provider in 2016/17 and Brighton and Sussex University Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided.

The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals was eligible to participate in during 2016/17 are as follows:

- Mental Health
- Acute Pancreatitis
- Acute Non Invasive Ventilation
- Chronic Neurodisability
- Young People’s Mental Health
- Cancer in Children, Teens and Young Adults
- Maternal, Newborn and Infant Clinical Outcome Review Programme: Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity
- Asthma (paediatric and adult) care in emergency departments
- National Neurosurgery Audit Programme
- BAUS Urology Audits: Nephrectomy
- BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)
- BAUS Urology Audits: Stress Urinary Incontinence Audit
- Specialist rehabilitation for patients with complex needs following major surgery
- National Emergency Laparotomy Audit (NELA)
- National Joint Registry (NJR)
- RCEM Severe sepsis & septic shock
- Major Trauma: The Trauma Audit & Research Network (TARN)
- National Bowel Cancer Audit (NBOCAP)
- Head and neck oncology (DAHNO/HANA)
- Lung cancer (NLCA)
- Oesophago-gastric cancer (NAOGC)
- Myocardial Ischaemia National Audit Project (MINAP)
- National Adult Cardiac Surgery Audit (ACS)
• Coronary angioplasty
• National Heart Failure Audit
• National Cardiac Arrest Audit (NCAA)
• National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)
• Diabetes (Adult) ND(A)
• Diabetes (Paediatric) (NPDA)
• Falls and Fragility Fractures Audit Programme (FFFAP): 3. National Hip Fracture Database
• Neonatal intensive and special care (NNAP) (subscription funded from April 2012)
• Endocrine and Thyroid National Audit (British Association of Endocrine and Thyroid Surgeons)
• Paediatric pneumonia (British Thoracic Society)
• Adult Asthma
• Case Mix Programme (CMP) ICNARC
• Diabetes (Adult): National Diabetes Footcare Audit
• Diabetes (Adult): National Pregnancy in Diabetes Audit
• Diabetes (Adult): National Diabetes Inpatient Audit
• Inflammatory Bowel Disease (IBD) programme
• National Ophthalmology Audit
• Renal replacement therapy (Renal Registry)
• Rheumatoid and Early Inflammatory Arthritis (EIA):
  • Sentinel Stroke National Audit Programme (SSNAP): SSNAP Clinical Audit / Post Acute Organisational Audit
• UK Cystic Fibrosis Registry
• Cardiac Rhythm Management (CRM)
• Congenital Heart Disease (CHD)
• PROMS: Hip replacement, Knee replacement, Hernia repair, Varicose Veins

• National Comparative Audit of Blood Transfusion programme: 3. 2016 Audit of the use of blood in Haematology
• National Audit of Dementia Round 3
<table>
<thead>
<tr>
<th>National Clinical Audit &amp; Enquiry Project name</th>
<th>Eligible</th>
<th>BSUH Participated</th>
<th>% of eligible/required cases submitted to the audit for 2016/17</th>
<th>Action taken, or planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Report published 26/1/17. Gap analysis is ongoing</td>
</tr>
<tr>
<td>Acute Pancreatitis</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Acute Non Invasive Ventilation</td>
<td>Yes</td>
<td>Yes</td>
<td>60%</td>
<td>Publication date June 2017</td>
</tr>
<tr>
<td>Chronic Neurodisability</td>
<td>Yes</td>
<td>Yes</td>
<td>89%</td>
<td>Publication date November 2017</td>
</tr>
<tr>
<td>Young People's Mental Health</td>
<td>Yes</td>
<td>Yes</td>
<td>89%</td>
<td>Please note this study is still open and the figures have not been finalised</td>
</tr>
<tr>
<td>Cancer in Children, Teens and Young Adults</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Please note this study is still open and the figures have not been finalised</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme: Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity</td>
<td>Yes</td>
<td>Yes</td>
<td>data not available</td>
<td>Awaiting results for 2016</td>
</tr>
<tr>
<td>Asthma (paediatric and adult) care in emergency departments</td>
<td>Yes</td>
<td>Yes</td>
<td>not applicable</td>
<td>Report not yet available</td>
</tr>
<tr>
<td>National Neurosurgery Audit Programme</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>This data is published online and is accessible to the public. Last year's audit showed no individual or unit outliers in patient outcomes.</td>
</tr>
<tr>
<td>BAUS Urology Audits: Nephrectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>All patients are entered onto a dedicated database after their procedure and all Consultant operators have their data published online, available for public scrutiny. There have been no concerns raised about any of the outcome markers.</td>
</tr>
<tr>
<td>BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>All patients are entered onto a dedicated database after their procedure and all Consultant operators have their data published online, available for public scrutiny. There have been no concerns raised about any of the outcome markers.</td>
</tr>
<tr>
<td>BAUS Urology Audits: Stress Urinary Incontinence Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>All patients are entered onto a dedicated database after their procedure and all Consultant operators have their data published online, available for public scrutiny. There have been no concerns raised about any of the outcome markers.</td>
</tr>
<tr>
<td>Specialist rehabilitation for patients with complex needs following major surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>not applicable</td>
<td>Participation in the first year required completion of an organisational audit questionnaire. The clinical audit, currently underway, utilises data collected via the existing Trauma and Research Network (TARN) Audit.</td>
</tr>
<tr>
<td>National Clinical Audit &amp; Enquiry Project name</td>
<td>Eligible</td>
<td>BSUH Participated</td>
<td>% of eligible/required cases submitted to the audit for 2016/17</td>
<td>Action taken, or planned</td>
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</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Yes</td>
<td>Yes</td>
<td>96%</td>
<td>We have: increased consultant surgeon/anaesthetist involvement (from 55% previously to now consistently over 80%); implemented better risk assessment and perioperative planning; implemented a checklist ‘boarding card’ for theatre booking; made regular use of data mapping on run charts for real-time QI intervention; achieved a reduction in length of stay (from 23days to 18days); achieved a reduction in risk adjusted 30day mortality from 11% in 2015 to approximately 5% in 2016/17.</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Yes</td>
<td>Yes</td>
<td>&gt;90%</td>
<td>The trust continues to actively participate in the National Joint Registry and data shows continued improvement.</td>
</tr>
<tr>
<td>RCEM Severe sepsis &amp; septic shock</td>
<td>Yes</td>
<td>Yes</td>
<td>not applicable</td>
<td>Report not yet available</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The Trust is submitting better and more timely data to the Trauma Audit and Research Network (TARN) and a new member of staff has been appointed to support this. A costed action plan has been developed to address the recommendations of the NHS England Major Trauma Centre (MTC) review and the Trust Board has already agreed initial funding to support the development of the MTC. The action plan will include rapid access to diagnostic and therapeutic staff and we are working with partners to ensure the appropriate early transfer of patients both in and out of the MTC according to patients’ care needs. We are working closely with our partners to strengthen our care pathways and recently held a network conference which brought together national and local expertise.</td>
</tr>
<tr>
<td>National Bowel Cancer Audit (NBOCAP)</td>
<td>Yes</td>
<td>Yes</td>
<td>89%</td>
<td>The Trust has less administrative support for completing this audit compared to neighbouring hospitals and there is a concern about the accuracy of BSUH data because of this. The audit data reflects BSUH’s currently very significant waits for patients requiring stoma reversal surgery. This will be resolved by October 2017.</td>
</tr>
<tr>
<td>Head and neck oncology (DAHNO/HANA)</td>
<td>Yes</td>
<td>Yes</td>
<td>data not available</td>
<td>BSUH continues to participate in this national audit which is currently undergoing some changes. National audit results are reviewed at Tumour Group meetings and more focussed local audits are also undertaken.</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>Yes</td>
<td>Yes</td>
<td>data not available</td>
<td>National audit results are reviewed at Tumour Group meetings and more focussed local audits are also undertaken.</td>
</tr>
<tr>
<td>National Clinical Audit &amp; Enquiry Project name</td>
<td>Eligible</td>
<td>BSUH Participated</td>
<td>% of eligible/required cases submitted to the audit for 2016/17</td>
<td>Action taken, or planned</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
<td>Yes</td>
<td>61-70%</td>
<td>National audit results are reviewed at Tumour Group meetings and more focussed local audits are also undertaken.</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>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.</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit (ACS)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The outcomes reports are regularly reviewed at specialty clinical governance meetings and specialty management meetings, and are compared with peer trusts.</td>
</tr>
<tr>
<td>Coronary angioplasty</td>
<td>Yes</td>
<td>Yes</td>
<td>99%</td>
<td>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 are available for public review.</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Through the Enhancing Quality programme, audit data is reviewed regularly and compared with other trusts in the region. An additional Heart Failure (HF) consultant and specialist nurse have been recruited to the Princess Royal Hospital during 2016/17, enabling a much higher number of HF inpatients to be seen by a HF specialist during their admission.</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
<td>No</td>
<td>not applicable</td>
<td>Participation in this national audit requires the Trust to subscribe to the NCAA. To date, the Resuscitation Operational Management Group (ROMG) has decided not to subscribe as it is costly with no real benefit to the Trust. The ROMG reviews this question of subscription annually. BSUH has, however, for a number of years, carried out an annual local audit of cardiac arrest data that is more comprehensive than the national audit and therefore more valuable. Results of the local audit are consistently high.</td>
</tr>
<tr>
<td>National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)</td>
<td>Yes</td>
<td>Yes</td>
<td>98-99%</td>
<td>The trust’s outcomes are reviewed regularly, and for aortic aneurysm repairs, carotid endarterectomy and amputations the outcomes are better than the national median results.</td>
</tr>
<tr>
<td>Diabetes (Adult) ND(A)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The audit report on secondary care is awaited.</td>
</tr>
<tr>
<td>National Clinical Audit &amp; Enquiry Project name</td>
<td>Eligible</td>
<td>BSUH Participated</td>
<td>% of eligible/required cases submitted to the audit for 2016/17</td>
<td>Action taken, or planned</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------</td>
<td>------------------</td>
<td>--------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>2015/16 results show the team is doing better than national average in many areas – showing continued improvement in HbA1c from previous years. The median HbA1c is lower than national average (% with good control is higher than national average and % with poor control is lower than national average) and % of pump patients is also improving as compared to previous years. Areas for improvement include identifying reasons for and rectifying high missing data re ethnicity and lower completion of TFTs. There has been a continued and increased workload (25% increase in the last 2 years) and therefore there is an urgent need for multidisciplinary team expansion. A business case is being prepared to seek this additional support. Data collection for 2016/17 is ongoing.</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): 3. National Hip Fracture Database</td>
<td>Yes</td>
<td>Yes</td>
<td>&gt;90%</td>
<td>The database continues to show excellent results for BSUH, which is in the top 5 trusts nationally for mortality rates.</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP) (subscription funded from April 2012)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Currently the units are almost always at or above levels reached by similar Neonatal Intensive Care Units in this audit programme. Disappointingly we fail to comply with standards surrounding temperature on admission. Plans have been agreed to address this.</td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit (British Association of Endocrine and Thyroid Surgeons)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Consultant-level data is available online. Developments taking place with the database will soon allow clinicians to review their data and results more contemporaneously.</td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
<td>Yes</td>
<td>No</td>
<td>Not applicable</td>
<td>Trust has not participated, due to lack of resources within the department at the time of this audit.</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Publication of the national report is awaited, and review of the results is due to take place at the next respiratory clinical governance meeting.</td>
</tr>
<tr>
<td>Case Mix Programme (CMP) ICNARC</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Quarterly benchmarking reports are circulated and reviewed regularly amongst the directorate.</td>
</tr>
<tr>
<td>Diabetes (Adult): National Diabetes Footcare Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>50% to date</td>
<td>Resources have not allowed for submission of data to this audit in previous years. However, data entry was commenced on 2nd January 2017.</td>
</tr>
<tr>
<td>Diabetes (Adult): National Pregnancy in Diabetes Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The team has submitted the first full year’s tranche of data for 2016. Data was complete and showed no outliers. The team will now be carrying out a detailed local review of the data and outcomes.</td>
</tr>
</tbody>
</table>
### Part 2

<table>
<thead>
<tr>
<th>National Clinical Audit &amp; Enquiry Project name</th>
<th>Eligible</th>
<th>BSUH Participated</th>
<th>% of eligible/required cases submitted to the audit for 2016/17</th>
<th>Action taken, or planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (Adult): National Diabetes Inpatient Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>To improve the documentation of foot assessments, a foot examination section has been included in the medical single clerking proforma and a dedicated foot assessment section has been included in the nursing pressure area risk assessment form.</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The national audit has prompted more focused local audit of some aspects, e.g. extended steroid use. This has uncovered a lot of primary care prescribing which we are trying to discourage. To this end we have developed how to treat your own flare guidelines, improved access to and use of the helpline, and written an information sheet on steroids. All patients starting on thiopurines are now seen regularly in the pharmacy service and we are much better at picking up those patients who require escalating therapy.</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>Yes</td>
<td>No</td>
<td>not applicable</td>
<td>The Ophthalmology department continues to seek to procure the relevant software that will allow participation in the audit and provide additional benefits of an electronic record.</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>BSUH makes automated submissions to the UK Renal Registry every year via the Sussex Kidney Unit (SKU). Regular Clinical Governance Meetings are held each year, which include an audit presentation resulting in the development of an action plan, reviews of all renal deaths and presentations of after-action reviews of any cases that are of concern.</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis (EIA):</td>
<td>Yes</td>
<td>Yes</td>
<td>not applicable</td>
<td>The Rheumatology Department is developing an enhanced EIA service and is working with GP groups to increase the quality of EIA referrals. The trust already has two dedicated EIA consultant clinics. Additionally, two consultants with the required skills for sonographic joint assessment have been employed in the last year and the department is submitting a business case to purchase a musculoskeletal ultrasound machine. There is some evidence to show that this would have a significant impact on patient management.</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP): SSNAP Clinical Audit / Post Acute Organisational Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>&gt;90%</td>
<td>As in previous years, high case ascertainment to the audit puts BSUH in Band A. Quarterly results are reviewed regularly and efforts made to address areas where scores are lower. A business case document has therefore been submitted this year, seeking increased therapist staffing to improve the level of multidisciplinary input for our patients. If successful, this is expected to lead to improved scores in a number of the national audit domains.</td>
</tr>
<tr>
<td>National Clinical Audit &amp; Enquiry Project name</td>
<td>Eligible</td>
<td>BSUH Participated</td>
<td>% of eligible/required cases submitted to the audit for 2016/17</td>
<td>Action taken, or planned</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The UK Cystic Fibrosis Registry is a secure centralised database that records health data on consenting people with cystic fibrosis.</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>All pacing cases are submitted to the NICOR database, where procedure numbers and complications are recorded and will soon be published. All excluded device cases are discussed at a weekly MDT and we have had 2 audits from NHS England to ensure compliance. We have had positive feedback from these and have improved our documentation in response to this feedback. All cases are also audited internally and reviewed at clinical governance meetings.</td>
</tr>
<tr>
<td>Congenital Heart Disease (CHD)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>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.</td>
</tr>
<tr>
<td>PROMS: Hip replacement, Knee replacement, Hernia repair, Varicose Veins</td>
<td>Yes</td>
<td>Yes</td>
<td>88%</td>
<td>The trust’s participation rate remains high, having increased slightly from the previous year’s rate. Patient reported outcomes for hip replacements have shown an improvement over the last year, and are within the normal range, as are those for groin hernia and varicose vein surgery. Knee replacement outcomes continue to be lower than expected according to the nationally-applied formula. However, review of the data indicates that the PROMS tool is not sensitive enough to adequately account for the patient casemix at the complex end of the spectrum of patients that are treated at BSUH.</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme: 3. 2016 Audit of the use of blood in Haematology</td>
<td>Yes</td>
<td>No</td>
<td>not applicable</td>
<td>Staff illness prevented participation in the latest round of this audit. Nevertheless audit reports and recommendations are taken to the Patient Blood Management Committee, which meets three times annually, for review, discussion and action.</td>
</tr>
<tr>
<td>National Audit of Dementia Round 3</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>The national report is due to be published in June/July 2017, and BSUH intends to participate in the action planning workshops taking place in Sept 2017, involving clinicians from other trusts nationwide.</td>
</tr>
</tbody>
</table>
Local clinical audits

Teams and specialties across the Trust have undertaken a wide range of local clinical audits in 2015/16. The reports below are a representative sample of those local clinical audits which were reviewed by the Trust in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Project Title</th>
<th>Actions to improve the quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Trust-wide</td>
<td>Trust-wide Audit of Consent</td>
<td>Following the audit, the Trust has identified local champions for cascading and raising awareness around the process of consent. The Trust have signed up to the EIDO patient information website providing procedure and condition specific information for patients which is available in several different languages.</td>
</tr>
<tr>
<td>2 Pharmacy</td>
<td>Antibiotic Point Prevalence Audit</td>
<td>Month on month improvement in review of antibiotic prescriptions achieved by increased focus on anti-microbial stewardship and reporting results monthly to each directorate.</td>
</tr>
<tr>
<td>3 Paediatric Surgery</td>
<td>Are Paediatric Surgical Day Cases Receiving Optimal Analgesia After Discharge?</td>
<td>We learned that a more structured approach to post-operative pain control targeting painful procedures may lead to better outcomes and patient satisfaction. We are revising the advice given to parents regarding analgesia for the postoperative period and will evaluate these findings further.</td>
</tr>
<tr>
<td>4 Trauma and Orthopaedics</td>
<td>Fracture Neck of Femur – Tip-Apex Distance (TAD) Audit.</td>
<td>Following identification of a higher than desired TAD contributing to the failure of a DHS, an audit was undertaken. Following a teaching and poster campaign, the proportion of TAD less than 2.5cm improved from 18% to 3% post intervention.</td>
</tr>
<tr>
<td>5 Acute Medicine</td>
<td>The use of Troponin blood tests in cardiac sounding chest pain</td>
<td>The clerking proforma at PRH has been updated to match that used at RSCH with clear instruction to measure Troponin at admission and 6hrs, thereby prompting staff to follow the NICE guidance relating to Troponin blood tests in this group of patients.</td>
</tr>
<tr>
<td>6 Anaesthetics</td>
<td>Epidural documentation audit / PCA Chart Documentation Audit</td>
<td>Adherence to observation times in Recovery units has improved since 2014. The observation charts are being re-designed in response to the audits to make them easier for the nurses to follow and indicate when the next observation is due.</td>
</tr>
<tr>
<td>7 Elderly Medicine</td>
<td>Accuracy of VTE prophylaxis prescription in patients with severe renal failure</td>
<td>This audit identified a 100% compliance rate with Trust Guidance for VTE prophylaxis in patients with severe renal failure reducing the risk of bleeding. The team will continue to keep this under review.</td>
</tr>
<tr>
<td>8 Haematology</td>
<td>An audit of Neutropenic sepsis</td>
<td>In order to improve performance regarding the time taken for patients to receive anti-biotics, the team is undertaking further work to identify the barriers to achieving the 100% target.</td>
</tr>
<tr>
<td>Specialty</td>
<td>Project Title</td>
<td>Actions to improve the quality of care</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>9 Intensive Care Unit</td>
<td>Catheter related bloodstream infections (CRBSI)</td>
<td>Comparison with international standards for CRBSI rates indicated that BSUH were consistently below the standard (0.25 crbsi/1000 catheter days vs standard of 1.4). The team are continuously monitoring this indicator to ensure continued high standards.</td>
</tr>
<tr>
<td>10 Urology</td>
<td>Improving the quality of urology operation notes</td>
<td>The results of this audit were reviewed at the departmental clinical governance meeting. The team have developed templates for common urological procedures which have been disseminated amongst the surgeons. A re-audit is planned.</td>
</tr>
<tr>
<td>11 Digestive Diseases</td>
<td>JAG Adenoma &amp; Polyp Detection Rate in Colonoscopies</td>
<td>This is a regular audit which identifies actions required to sustain and improve the quality of patient care with regards to adenoma/polyp detection.</td>
</tr>
<tr>
<td>12 Anaesthetics</td>
<td>BM monitoring in neurosurgical patients who are prescribed steroids</td>
<td>The team are planning to present the results to all clinical groups involved in the care of these patients and to work with the Endocrinology team to create hospital guideline. A re-audit is planned to assess the impact of the interventions.</td>
</tr>
<tr>
<td>13 Neurology</td>
<td>Audit of the safety and clinical outcomes of patients undertaking video EEG telemetry at Hurstwood Park</td>
<td>Diagnostic rate of 89% was similar to past studies and provided evidence that the VT service at Hurstwood Park is an accurate method in determining seizure type. The findings will be used to help with business planning to support further improvements to the service.</td>
</tr>
<tr>
<td>14 Ophthalmology</td>
<td>Ophthalmology Clinic Outcome Form. Audit and Re-audit</td>
<td>Results of the initial audit were presented to the departmental clinical governance meeting. Following training sessions for staff the re-audit showed improvement in all areas.</td>
</tr>
<tr>
<td>15 Neonatology</td>
<td>Non-Invasive Respiratory Management Audit</td>
<td>The audit found that overall practice was in keeping with general evidence. The current guidelines will now be adjusted to reflect developments in best practice and the audit will be continued.</td>
</tr>
<tr>
<td>16 Diabetes/Endocrinology</td>
<td>Review of all Datix incidents, patient safety issues and complaints</td>
<td>The review identified some common themes. A suite of targeted interventions has been devised including education and improved guidelines to address the issues raised.</td>
</tr>
<tr>
<td>17 Ear Nose &amp; Throat</td>
<td>Audit of ENT department consent policy</td>
<td>This regular audit raises awareness about the consent process and has shown an improvement over the last 4 cycles. The audit will be continued as the process of consent is continually revised in the Trust to address rising expectations.</td>
</tr>
<tr>
<td>18 Imaging</td>
<td>Reject Analysis Audit</td>
<td>This continuous data collection audit gives feedback to radiographers in Sharing Good Practise sessions to ensure ongoing improvements and high quality images.</td>
</tr>
</tbody>
</table>
Part 2

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Project Title</th>
<th>Actions to improve the quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 Pathology</td>
<td>Introduction of Monthly Managerial and Quality Reporting</td>
<td>This project aims to move all pathology services to a leaner and more effective quality of service delivery. The team are currently devising the initial proformas to take this work forwards.</td>
</tr>
<tr>
<td>20 Trauma &amp; Orthopaedics</td>
<td>Proximal Humeral Fracture Fixation Audit</td>
<td>Compared with published data, BSUH showed a lower rate of infection; lower rate of avascular necrosis (AVN); similar re-operation rate; higher rate of varus malunion (loss of position); higher rate of screw penetration. Future work will focus on assessing the effect of varus or valgus fracture orientation on loss of position; and assess the effect of augmented screws with or without cement on screw penetration and collapse. Re-audit planned for May 2017.</td>
</tr>
</tbody>
</table>

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Brighton and Sussex University Hospitals NHS Trust in 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 3206.

Participation in clinical research demonstrates Brighton Sussex University Hospitals NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Brighton and Sussex University Hospitals NHS Trust was involved in conducting over 260 clinical research studies in 22 clinical specialities the most research active of which are Paediatric Medicine, Cancer, Cardiovascular Disease, HIV Medicine, neurological disorders, Orthopaedic Surgery, Rheumatology and Renal Disorders.

In the last three years, more than 600 publications have resulted from our involvement in clinical research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with research and all phases of clinical trials sponsored by commercial and academic bodies demonstrates Brighton and Sussex University Hospitals NHS Trust’s commitment to testing and offering the latest medical treatments and techniques.
Use of the CQUIN payment framework

A proportion of the Trust’s income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: https://www.bsuh.nhs.uk/about-us/
Statements from the CQC

Brighton and Sussex University Hospitals NSH Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission (CQC) conducted an inspection of the Trust in April 2016.

The Trust was rated *inadequate* overall and a section 29a Warning Notice was served on the Trust in June 2016. The Warning Notice identified significant failings in the 3 areas below and required significant improvements to be made by 30th August 2016.

1. Your systems to assess, monitor and mitigate risks to people receiving the care as inpatients and outpatients are not operated effectively.
2. Your systems to assess, monitor, and improve the care and, privacy and dignity of people attending your hospitals as inpatients and outpatients are not operated effectively.
3. Your systems to ensure patients are seen in line within national timescales for treatment are not operating effectively.

<table>
<thead>
<tr>
<th>Table 1: CQC inspection report ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe</strong></td>
</tr>
<tr>
<td>RSCH Urgent &amp; Emergency Services</td>
</tr>
<tr>
<td>PRH Urgent &amp; Emergency Services</td>
</tr>
<tr>
<td>RSCH Critical Care</td>
</tr>
<tr>
<td>PRH Critical Care</td>
</tr>
<tr>
<td>RSCH Medical Care</td>
</tr>
<tr>
<td>PRH Medical Care</td>
</tr>
<tr>
<td>RSCH Surgery</td>
</tr>
<tr>
<td>PRH Surgery</td>
</tr>
<tr>
<td>RSCH Maternity</td>
</tr>
<tr>
<td>PRH Maternity</td>
</tr>
<tr>
<td>RSCH Outpatients and Diagnostics</td>
</tr>
<tr>
<td>PRH Outpatients and Diagnostics</td>
</tr>
</tbody>
</table>
Quality Summit

A Quality Summit was held on 15th August. This was attended by Trust Executive Directors and representatives of CQC, NHS Improvement, NHS England, the CCGs and Health Overview and Scrutiny Committees and the Trust presented its action Plan in response to the CQC inspection report findings.

Special Measures

Subsequent to the CQC inspection, NHSI placed the Trust in Special Measures in August 2016.

Action Plan

The Trust developed a detailed action plan to address the findings of the Warning Notice and inspection reports which has been reported monthly to the Quality and Performance Committee and Board.

This comprised part of a broader integrated recovery plan approved by the Board in September 2016. This plan addressed issues related to quality and safety, financial, clinical services, and workforce and leadership, governance, communications, performance management, information and technology, and strategy and transformation. The Recovery Plan aimed to provide a single view to regulators, staff, and the public of the Plan to address the issues the Trust faced.

CQC carried out an assessment of progress with the requirements of the Warning Notice in January 2017 and agreed that no further enforcement action was required.

CQC Assessment January 2017

A full re-inspection will take place in April 2017.

The Trust had made the following progress by 31st March 2017/18 in taking the actions required.

<table>
<thead>
<tr>
<th>Reg 10 – Service users must be treated with dignity and respect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirement</td>
</tr>
<tr>
<td>------------</td>
</tr>
</tbody>
</table>
| 10.01 | Ensure that patients’ dignity, respect and confidentiality are maintained at all times in all areas and wards. | X | X | MUST | • IG training improved  
• Records security improved  
• Clinic room privacy improved  
• ED Corridor privacy improved  
• Audits of compliance in hand to ensure embedding  
• Need to pursue separation of sexes in imaging waiting areas, then whole programme for monitoring to ensure embedding of good practice  
• Outpatient privacy and dignity audit performed monthly  
• Review results of annual privacy and dignity audit |

G
### Reg 12 – Care and treatment must be provided in a safe way for service users

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Trust</th>
<th>RSCH</th>
<th>PRH</th>
<th>Must/should</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.02 Improve the safety and welfare of patients in the cohort / corridor area of ED</td>
<td></td>
<td>X</td>
<td></td>
<td>WARNING</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTICE</td>
<td></td>
</tr>
<tr>
<td>• Comfort rounds in place and well completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NEWS scoring implemented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No pts in corridor with NEWS &gt;4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessment &amp; treatment cubicles opened</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Risk assessments conducted consistently</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mental health risk assessments conducted consistently</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Further adaptations to corridor post fire risk assessment completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nursing notes project continues with delays due to staff sickness - this may have given rise to reduced performance in respect of safety etc. checks. New nursing notes format withdrawn and previous iteration back in use.</td>
<td></td>
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</tr>
<tr>
<td>12.03 Establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.</td>
<td>X</td>
<td>X</td>
<td></td>
<td>MUST</td>
<td>A</td>
</tr>
<tr>
<td>• Review completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Need for enhanced neuro skills training acknowledged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bed capacity reduced pending neuro skills increase</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• In-house training programme implemented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Neuro Practice Educator has resigned, risk added to programme pack</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Numbers of neuro-trained nurses decreasing. Associated risks and issues discussed at SMT 06.03.17; further mitigation work in planning phase.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.04 Implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.</td>
<td>X</td>
<td></td>
<td></td>
<td>MUST</td>
<td>B</td>
</tr>
<tr>
<td>• Corridor use reduced, but still happens.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Measures to avoid use in place (Escalation Policy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment / assessment cubicles in use for delivery of care</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Treatment and assessments conducted in corridor on one occasion in February. Fully risk assessed as least worst option, and reported as incident. No further incidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Result of report from Trust auditors to be reviewed</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Reg 12 – Care and treatment must be provided in a safe way for service users

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Trust</th>
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<th>Progress</th>
</tr>
</thead>
</table>
| 12.05 Adhere to the 4 hour standard for decision to admit patients from ED, i.e. patients should not wait longer than 4 hours for a bed | X | X | MUST | • Performance improving, but not at required standard yet  
• Performance affected by winter pressures  
• Trust at improved rank amongst other reporting trusts, despite relatively static performance against target  
• Improved focus on 4 hour target as a result of reduced incidence of 12 hour breaches  
• Action downgraded as a result of more realistic assessment | A |
| 12.06 Stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff. | X | X | MUST | • Transfer of patients from ED / HDU virtually eliminated until mid-December, but 4 recent cases  
• Recent cases reflect winter pressures but risk assessed on each occasion (1 ED patient, 3 ward patients)  
• A few incidents of transfer of patients from wards to ICU upon deterioration continuing through February and March  
• Meeting set up with relevant parties to discuss  
• Behaviours training programme drawn up but not yet delivered | A |
| 12.07 Ensure that resuscitation/emergency equipment is always checked according to the trust policy. | X | MUST | • Resuscitation trolley checks added to safety huddle template  
• Ward managers conducting monthly audits of daily checks; results reported to Resuscitation Committee  
• See also 12.15 – checklist to be revised once tamper-evident boxes installed  
• Yearly audit by resus team in place but individual ward managers responsible for daily and weekly checks in line with the policy/new trollies. Resus team offer training and advice alongside new trollies.  
• Resus team conducts spot checks when they are in an area for training etc.  
• Annual audit information collated and report taken to Resus Committee and then onto Q&P committee.  
• 72 out of 125 new trollies in place at RSCH.  
• PRH trollies will be rolled out from 20th March.  
• Training on checks process and paperwork to accompany trollies is undertaken by Resus team with ward managers on implementation of new trolley. | G |
### Reg 12 – Care and treatment must be provided in a safe way for service users

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Trust</th>
<th>RSCH</th>
<th>PRH</th>
<th>Must/should</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 12.09 Meet cancer waiting and treatment time targets | X | X | WARNING NOTICE | • 31 day targets met consistently since August  
• 62 day target met in September; trajectory for consistent compliance from February  
• Below trajectory for 62 day compliance in January and February. Recovery plan underway, compliance expected from April 2017. |
| 12.10 Reduce the number of cancelled operations, particularly those for patients whose operations is cancelled without completion of their treatment within 28 days | X | X | WARNING NOTICE | • Cancelled ops rate significantly reduced  
• Only 4 pts not treated within 28 days of cancellation since w/e 24.10.16.  
• December performance reflects NHSE requirement to reduce elective work during December and January  
• Apparent issue with MSK, some patients being cancelled 4-5 times (need to review status)- status of action downgraded pending enquiries |
| 12.11 Must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids. | X | X | MUST | • September security audit completed 89% compliant across the trust  
• Action plans for non-compliant areas developed  
• December audits not completed because of lack of Pharmacy capacity. Approx 25% completed during January. Feedback provided to non-compliant areas  
• Review of security of all clinical rooms and medicines cupboards underway with a view to improving consistency of approach to locks etc. |
| 12.12 Ensure staff are working under appropriately approved Patient Group Directions (PGDs). Ensure PGDs are reviewed regularly and up to date | X | X | MUST | • All PGDs reviewed and updated  
• System for regular review implemented  
• PGD spot check undertaken alongside the FP10/outpatient prescription – good compliance with PGDs noted |
| 12.16 Must take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved. | X | X | MUST | • Overall 18 RTT 84.16% (target 92%) but above improvement trajectory |
Reg 15 – All premises & equipment used by the service provider must be – clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained, and appropriately located for the purpose for which they are being used.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Trust</th>
<th>RSCH</th>
<th>PRH</th>
<th>Must/should</th>
<th>Progress</th>
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</table>
| 15.01 Ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety. | X | X | MUST | • Jubilee building closed  
• Barry building balcony beds closed  
• Allocation protocol revised  
• Audit of transfer documentation taking place monthly  
• Risk assessment of extra capacity beds in escalation policy completed  
• Daily ward safety checklist being standardised  
• Environmental (H&S) risk assessments required – additional resource has been allocated to ensure completion. |
| 15.04 Review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required. | X | X | MUST | • Hand hygiene audits continue, with variable results  
• Human Factors workshop to examine non-compliance issues booked for July (see update below)  
• Various hand hygiene campaigns in place, including formal warning letters from Chief Nurse / Medical Director  
• Infection Control issues included in OPD Nursing Checklist  
• Infection control issues included in safety huddles  
• 09/03/17 Funding approved for Human factors workshops on hand hygiene |
| 15.06 Review fire plans and risk assessments ensuring that patients, staff and visitors to the hospital can be evacuated safely in the event of a fire. This plan should include the robust management of safety equipment and access such as fire doors, patient evacuation equipment and provide clear escape routes for people with limited mobility. | X | MUST | • All fire plans and risk assessments complete  
• Work on remedial action completed in some areas, in hand in all others  
• A new action plan template is being developed to promote more effective monitoring and reporting of all FRA actions. |
### Reg 17 – Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part

<table>
<thead>
<tr>
<th>SAFER STAFFING</th>
<th>Trust</th>
<th>RSCH</th>
<th>PRH</th>
<th>Must/should</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.01 Review the actual risk of the Alert computer system.</td>
<td>X</td>
<td>MUST</td>
<td>• Risk assessment completed; replacement agreed, • Replacement completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.03 The trust must monitor the turnaround time for biopsies for suspected cancer of all tumour sites.</td>
<td>X</td>
<td>MUST</td>
<td>• Progress hampered by historic inadequate investment in IT • Investment in staff and IT now agreed • Other aspects of 2WW timetable compressed to accommodate diagnostic delays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.04 Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates. This includes learning from incidents, safeguarding and complaints across the directorates</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
<td>• Review of clinical and quality governance arrangements in all directorates in hand • Monday Message includes patient safety stories • Patient Safety podcasts published</td>
<td></td>
</tr>
<tr>
<td>17.05 Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
<td>• Senior Management Team (SMT) created and meeting weekly</td>
</tr>
<tr>
<td>17.06 Continue to ensure lessons learnt and actions taken from never events, incidents are shared across all staff groups</td>
<td>X</td>
<td>MUST</td>
<td>• Monday Message includes patient safety stories • Patient Safety podcasts published • Patient safety newsletters published • Review of trust-wide clinical governance systems planned for early 2017/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.10 Improve risk management and reporting from ward to board</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>WARNING NOTICE</td>
<td>• Risk management strategy and process completely revised • Training programme reviewed and in delivery • Directorate risk reviews commenced • Reporting to Board resumed • Programme of communication to ward level staff about revised approach required • Environmental risk assessment status of some areas currently unknown – status downgraded until position clearer. Additional resource allocated</td>
</tr>
</tbody>
</table>
### Reg 17 – Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part

<table>
<thead>
<tr>
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<th>PRH</th>
<th>Must/should</th>
<th>Progress</th>
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</thead>
<tbody>
<tr>
<td>17.11 Improve processes and systems for ensuring that the Board seeks adequate assurance concerning the quality of care given to pts</td>
<td>X</td>
<td>X</td>
<td></td>
<td>MUST</td>
<td>WARNING NOTICE • Directorate and trust wide score cards now in regular use, including quality issues</td>
</tr>
<tr>
<td>17.12 Ensure safe and secure storage of medical records.</td>
<td>X</td>
<td></td>
<td></td>
<td>MUST</td>
<td>• IG training levels improved • Lockable storage facilities provided • Audits of compliance taking place in key areas • Need to extend audit to all areas • IG training currently 90% Trust wide (Target 95%) • Downgraded due to mock inspection results and observations of current practice.</td>
</tr>
<tr>
<td>17.13 Review funding for multidisciplinary specialties and ensure business cases submitted by specialists are considered appropriately. This specifically refers to pharmacy, occupational therapy and dietetics.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
<td>• Corporate Governance Review included establishment of Business Appraisals Committee (reports to FBI) • BAC met September and December but slightly stalled; will resume January 2017 • BAC now meeting fortnightly • External review of Pharmacy planned for Q4 • Guidance for Operational Planning to be revised to ensure adequate focus on support and multi-disciplinary services</td>
</tr>
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</table>

### Reg 18 – Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Trust</th>
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<th>PRH</th>
<th>Must/should</th>
<th>Progress</th>
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</thead>
<tbody>
<tr>
<td>18.02 Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
<td>• NHSI supported review of nurse staffing levels complete, going to January Board • Ward / dept benchmark of educational / skills need underway • Workforce modernization programmes in hand • Significant number of gaps in staff establishment across the Trust.</td>
</tr>
<tr>
<td>18.03 Ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
<td>• Induction programme completely reviewed and updated since last in use • Plan for 2017 cohort reflects feedback and learning from previous attendees</td>
</tr>
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### Part 2

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Trust</th>
<th>RSCH</th>
<th>PRH</th>
<th>Must/should</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Reg 18 – Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part</td>
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</tbody>
</table>
| 18.04 Implement an action plan to reduce further nurse sickness absence and attrition through a transparent, sustainable programme of engagement that must include a significant and urgent improvement in staff training | X | MUST | • Workforce modernization programmes support improved attendance / retention  
• Retention Lead Nurse in post and focused on newly qualified / appointed staff  
• Foundations of Care programme supports enhanced engagement, training, development, retention  
• Consciously Competent programme in place to improve training and development  
• Wellbeing sessions being run by Chaplaincy Team  
• Advance Care Practice (ACP) project phase 1 part of the Workforce Transformation programme is due to complete end of March and proposal for extension has been drafted. | G |
| 18.05 Adhere to RCN guidelines that the nurse coordinator remains supernumerary at all times. | X | MUST | • All nurse staffing templates show nurse coordinator as supernumerary  
• Review of equity of role underway | G |
| 18.07 Review consultant cover in the ED at PRH, per Royal College of Emergency Medicine guidance | X | WARNING NOTICE | • Consultant increase business case approved but recruitment not successful  
• Clinical Fellow programme implemented to help mitigate risks | G |
| 18.08 Review staffing and skills mix on ICU and cardiac ICU | X | WARNING NOTICE | • Sickness absence issues present during inspection period largely addressed but turnover and vacancy rates remain higher than desirable – further plans required  
• Nursing skill mix assessment completed; gaps identified. Business case in development | A |
| 18.09 Must undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity. | X | X | X | MUST  
• Skill mix reviewed  
• Bed capacity reduced to match neuro-trained staff resource  
• Staff development programme underway | B |
| 18.10 Review and improve medical and nursing cover to meet relevant CEM and RCPCH standards and reflect/review activity rates relating to paediatric for the unit. | X | MUST | • Review of paediatric attendance / need at PRH in hand  
• Mitigations in place and Board discussion of sustainable solution | R |
### Reg 18 – Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part

<table>
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<tr>
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<th>Must/should</th>
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</thead>
<tbody>
<tr>
<td>18.12 Ensure that all staff have attended mandatory training (including conflict resolution training and appropriate levels of safeguarding training)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• STAM levels achieved trajectory at year-end.</td>
</tr>
<tr>
<td>18.13 Review clinical training records for medical and nursing staff and rectify gaps in role specific resuscitation training such as ALS and PILS.</td>
<td></td>
<td>X</td>
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<td>MUST</td>
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<td></td>
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<td></td>
<td>• Discrepancy between data on IRIS and previous records makes position unclear</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Data quality issue being addressed</td>
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<td></td>
<td></td>
<td>• Capacity to provide and undertake specialist training limited by demands on clinical time due to winter pressures etc. but delivery being pursued</td>
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<td></td>
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<td></td>
<td></td>
<td>• Additional trainers being recruited to improve provision of training</td>
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<td></td>
<td>• 07/03/17 Review completed and gaps identified in A&amp;R specifically, report to follow</td>
</tr>
<tr>
<td>18.18 Undertake a review of the HR functions in the organisation, including but not exclusively recruitment processes and grievance management.</td>
<td>X</td>
<td>X</td>
<td></td>
<td>MUST</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• HR function review complete</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>• Recommended changes agreed by Board, but implementation delayed</td>
</tr>
<tr>
<td>18.19 Ensure all staff have an annual appraisal.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>MUST</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Appraisal levels achieved trajectory at year-end.</td>
</tr>
<tr>
<td>18.20 Develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.</td>
<td>X</td>
<td>X</td>
<td></td>
<td>MUST</td>
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<td></td>
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<td></td>
<td>• Diagnostic work to be commissioned during January</td>
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<td>• LGBT newsletter published regularly</td>
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<td></td>
<td></td>
<td>• &quot;People Together&quot; working in the trust currently to support development of strategy. Staff-side, BME Network, LGBT+ Forum all engaged in process.</td>
</tr>
</tbody>
</table>
Part 2

Data Quality

BSUH will be taking the following actions to improve data quality 2017/18:
• Review the accuracy and timeliness of our clinical coding and correction of errors
• Review the accuracy and completion of our CDS and correction of missing fields
• Improving GP assignment via our scheduled PAS upgrade
  Regular validation of waiting lists to ensure they reflect ‘active’ patients requiring treatment only

NHS Number and General Medical Practice Code Validity

Brighton and Sussex University Hospitals NHS Trust (BSUH) submitted records during April 2016 to January 2017 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

• which included the patient’s valid NHS number was:
  – 99.3% for admitted patient care;
  – 99.6% for out-patient care; and
  – 95.4% for accident and emergency care.

• which included the patient’s valid General Medical Practice Code was:
  – 99.9% for admitted patient care;
  – 99.9% for out-patient care; and
  – 99.7% for accident and emergency care.
Information Governance Toolkit attainment levels

Brighton and Sussex University Hospitals NHS Trust Information Governance Assessment

Report score overall score for 2016/17 was 67% and was graded green based on the following key:

- Not Satisfactory
- Satisfactory with plan of improvement
- Satisfactory

The Trust was fully compliant in relation to 36 of the 45 IG Toolkit requirements.

The Trust was partially compliant against 7 of the requirements and has developed action plans with the aim of making the necessary changes.

The following requirements were deemed to be partially compliant although action plans are not yet in place to address these:

<table>
<thead>
<tr>
<th>Req No:</th>
<th>Requirement Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-110</td>
<td>Organisations are responsible for obtaining appropriate contractual assurance in respect of compliance with Information Governance (IG) requirements from all bodies that have access to the organisation’s information or conduct any form of information processing on its behalf. This is particularly important where the information is about identifiable individuals.</td>
</tr>
<tr>
<td>14-506</td>
<td>Organisations should have procedures and a regular audit cycle to check the accuracy of service user data. The results of the audits should be reported as part of the organisation data quality reviews to the Board and be made available to the HSCIC on request. The audit should cover all key data items identified in ‘HSCIC: NHS IG - Key Data Items List’ found within the Knowledge Base Resources, or for mental health trusts - data items in the Mental Health Services Data Set, or a locally defined subset approved by specific formal agreement with the organisation’s main commissioner, or local Data Quality Informatics Group.</td>
</tr>
</tbody>
</table>

Clinical coding error rate

BSUH was not subject to the Payment by Results clinical coding audit during 2016-17 by the Audit Commission.
Part 3
Part 3

Performance against the 2016/17 quality improvement priorities

Reducing avoidable falls – Not achieved

Inpatient falls are a significant safety issue both locally and nationally, they are a source of increased length of stay, excess morbidity and avoidable mortality. When this project was initiated in 2009 the Trust reported over 1,500 inpatient falls per annum, whilst the most recent six monthly report from NHS England records over 119,000 patient falls in acute hospitals in England and Wales for the period up to March 2016.

Although not all falls can be prevented we have learnt that a significant number can be avoided.

We recognised last year that it would be extremely challenging to reduce the Trusts rate of falls for the seventh year running; consequently we aimed for a small reduction of 5%. Rather than a 5% reduction at year end the rate of falls for 2016-17 was 4.6% higher at 3.51 falls per 1000 bed stay days.

The 2015 Royal College of Physicians National Audit of Inpatient Falls identified the average falls rate in England and Wales as 6.63 falls per 1000 bed stay days. Based on the average national rate we could have expected to have 1755 falls, during the year 928 inpatient falls were reported, some 827 fewer than the average rate. Only one ward in the Trust had a higher falls rate than the national average.

Improvements delivered in financial year

We have shared the falls methodology approach that the Trust has developed at various collaborative forums in 2016 including the International Conference on Falls and Postural Stability and the Complexity and Management Conference. In collaboration with the University of Southern Denmark and Hertfordshire Business School a series of papers are currently being prepared for publication. The same team were also shortlisted by the Health Foundation programme Scaling up for Improvement.

Plan for 2017-18

The same two individual members of staff have led this initiative since 2009. The clinical lead for this project is now currently attempting to replicate the results in Brighton at a neighbouring acute Trust. Our focus for the forthcoming year is sustaining the Trusts falls rate, although
this project we not be carried forward as a 2017-18 priority the falls rate will continue to be monitored at the Trust’s Patient Safety Committee.

**Mortality – Partially achieved**

We are in the final phase of setting up the Medical Examiner programme at Princess Royal Hospital and will be recruiting new Medical Examiners early in the new financial year. Medical Examiners at RSCH are established as the first line in our mortality review process and regularly highlight issues with care which are then fed into departmental or Trust mortality review processes as appropriate.

There have been several national initiatives relating to mortality review and we have registered our interest in joining the Royal College of Physicians National Mortality Case Record Review Programme (RCP NMCRR) and using their structured data collection sheet for mortality review.

We have rolled out a feedback questionnaire for bereaved relatives. This is available in online and paper formats. Initial response rates were low but feedback was extremely positive and has identified areas for improvement. The positive feedback has been used to encourage staff to highlight the importance of the questionnaire to bereaved relatives. Response rates are now increasing.

Development of a Trust-wide database for recording mortality reviews has been put on hold pending the roll out of the Royal College of Physicians National Mortality Case Record Review Programme.

We have been unable to increase attendance at Trust wide Mortality Review Group from departmental leads due to difficulties in scheduling and co-ordinating with clinical workloads. Where there are specific concerns speciality leads are invited to present their data.

**Plan for 2017-18**

In December 2016, the Care Quality Commission published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England*. The focus for the Trust-wide Mortality Review Group in the next 12 months will be the implementation of these recommendations which include:

- Appointing an Executive Director to have oversight of the governance arrangements and process for reviewing hospital deaths.
- Appointing a non-executive director to be responsible for oversight of the process.
- A review of the skills and training required to support the review and investigation of hospital deaths.
- To collect and publish a quarterly report on hospital mortality.
- To produce a Trust policy for undertaking case note reviews.
- To recruit medical examiners to Princess Royal Hospital and begin delivering the service on that site.

**Enhanced recovery – Partially achieved**

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

The 2016-17 target set in gynaecology surgery was a cumulative appropriate care score (ACS) of 90.00% for patients discharged between April and December 2016. The ACS score is calculated as the number of patients who receive ALL the measures in the care bundle (a *care bundle* is a set of interventions that, when used together,
Part 3

significantly improve patient outcomes). To date we are currently recording an ACS score of 90.36%.

In colorectal surgery our target set was a cumulative ACS of between 82.62% - 87.98% for the period April 2016 to December 2016 discharges. Currently the Trust is achieving a cumulative ACS of 85.98%.

Our target in orthopaedic surgery is an ACS score between 83.63% - 88.39% unfortunately we are currently just missing this target with a cumulative ACS of 82.02%.

Introduction of the ERP pathway into other surgical areas is on-going, the Upper GI pathway is currently pending roll out and a Urology pathway is in development. Elective spinal surgery is also being reviewed as a potential pathway.

Plan for 2017-18

The original three ERP pathways (Orthopaedics, Gynaecology and Colorectal) are now business as usual. Whilst we have noticed a small slip in documentation and data collection since it was announced that the programmes are coming to an end at a regional level the learning continues to be implemented and pathways developed and updated internally.

Reducing harm from medication (medication reconciliation) – Partially achieved

The National Institute for Health and Care Excellence (NICE) have evidenced that medication errors occur most commonly during transfers between care settings and particularly at the time of admission. The aim of medicines reconciliation is to ensure that medicines prescribed to patients on admission correspond to those that the patient was taking before admission.

This initiative aimed to ensure that 90% of our inpatients have their medicines reconciled within 24 hours of admission.

The chart below details medicines reconciliation performance on a month by month basis during 2016/2017. Medicines reconciliation figures were collected as part of the monthly medicines safety thermometer (a national measurement tool developed to identify harm occurring from medication errors). Data collected on wards at the Royal Sussex, Princess Royal, Children’s Hospital and Eye hospital indicates that the Trust’s average medicines reconciliation for 2016/2017 was 69%. The 90% target for medicines reconciliation was achieved on eight wards. A further 22 ward areas achieved medicines a reconciliation rate of above 70%.

![Medicines Reconciliations completed within 24 hours of admission](chart.png)
Plan for 2017-18
Pharmacy will be targeting those areas achieving less than 90% medicines reconciliation focusing on the allocation of pharmacy resource to those areas achieving less than 70% medicines reconciliation within 24 hours.

Pharmacy staffing will also be reviewed with the primary aim being to better optimise the efficiency of our pharmacy staff across the trust.

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

During 2016-17 the Trust has continued to participate in collaborative learning events and the sharing of best practice within Kent, Surrey and Sussex.

Like the Enhanced Recovery initiative discussed earlier, performance is assessed using the appropriate care score (ACS) which is calculated as the number of patients who receive ALL measures in the care bundle.

For Chronic Obstructive Pulmonary Disease (COPD) our baseline from the previous year was a cumulative ACS of 83.9% with an improvement target of 83.95 – 89.12% for the period March 2016 to April 2017 discharges. There was no data completeness target set, although our baseline from last year was 50.2% - Our cumulative ACS to data for April to Sept 2016 discharges is 88.6% so we are on target. Final data not available but recent data shows progressive attainment of the appropriate care score (ACS). Length of stay has steadily fallen with rising ACS and the 30 day re-admission rate has remained steady (the 30-60 day and 61-90 day readmission rate have both fallen steadily as ACS compliance increases). Our aim is to increase the percentage of patients coded with primary COPD that we discharge bundle whilst still maintaining a high ACS.

As part of this programme the Trusts Heart Failure Service has continue to develop, a second heart failure consultant was appointed in the summer 2016 and a heart failure nurse specialist based at PRH was appointed in September 2016. These posts now mean that the Trust has an equitable service across our hospital sites.

Plan for 2017-18
These projects will not be being carried over to next year’s Quality Accounts. The CAP project has now been completed at a regional level and COPD and heart failure are being replaced by our involvement in the National Audits.

Improving care for the deteriorating patient – Sepsis– Partially achieved
Sepsis is a common and potentially life threatening condition where the body’s immune system goes into overdrive in response to an infection setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. Problems in achieving consistent recognition and rapid treatment are thought to contribute to the number of preventable deaths from sepsis every year.

During 2016-17 work continued on the early identification and treatment of patients who are at risk of sepsis on arrival at hospital. The focus of this work has been the development of a screening tool, the initiation of intravenous antibiotics within one hour, ‘appropriate’ antibiotic prescribing and antibiotic review within 72 hours. The Trust has appointed a Clinical Lead for Sepsis and Specialist Nurse to support this project to support learning and educational aspects of this initiative.

During Quarter 2 40% of patients in the Emergency Department received their antibiotics within one hour, in Quarter 3 this figure rose
to 50%. The target of a 10% improvement in Quarter 4 has been set in agreement with the local Clinical Commissioning Group. Results for Quarter 4 are pending.

Sepsis prevention

This year we plan to roll out the sepsis screening tool and training to all inpatient areas.

Changes to the A&E computer system will ensure sepsis screening becomes a mandatory process when a patient has a NEWS score of 4 or above (National Early Warning Score - a guide used by medical teams to quickly determine the degree of illness of a patient).

A sepsis E-learning module is planned along with the production of a Sepsis 6 video clip promoting sepsis awareness among staff.

Monthly audits of inpatient and Emergency Department patient notes are also scheduled.

Improving care for the deteriorating patient – Acute Kidney Injury (AKI) – Partially achieved

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

Our aim has been to improve the follow-up and recovery for individuals who have sustained an AKI, reduce the risks of readmission and re-establishing medication for other long term conditions by developing a process for:

- Early identification of patients who are at risk of developing an AKI.
- Alerting clinicians that their patient has sustained an AKI.
- Improving medication reviews.
- Improving the information communicated to primary care relating to on-going management after discharge.

Our targets for 2016/17 were to:

- Refine the transfer of information between healthcare sectors in patients with AKI (content, messaging and coding).
- Support existing task and finish groups (educational workshops, attendance at project meetings and roll-out of automated AKI alerts).
- Establish links and governance structures to support awareness and quality improvement in AKI in other Sussex Clinical Commissioning Groups.
- Support education and co-design of pathways for management, AKI avoidance and early recognition in out-of-hour’s services, care homes and community pharmacies.

During the past 12 months the group leading on this initiative have been testing the electronic ordering and diagnostic results information technology system (ICE) for automated AKI alerting. As part of this work an interface between ICE and PANDA (the in house patient results system) and the Trust email system has been developed which will send automated AKI alerts the signposting of AKI cases. The junior doctor’s handbook has been updated to include information on the management of patients with AKI. The number of nurses and health care assistants undertaking the AKI NICE e-learning course has increased. The AKI checklist has been
tested and evaluated in the Medical Assessment Unit. Guidance for heart failure AKI patients has also been produced.

**Acute kidney injury (AKI) prevention**

This year AKI ICE/PANDA alerting will be launched across the Trust. The AKI checklist and AKI heart failure guidance will be completed and usage scaled up. Improved measurement and monitoring will be used to inform teaching and training.

Simulation training for AKI and the deteriorating patient is planned. The feasibility of 24/7 support across the Trust for AKI 2 alerts will also be undertaken.

**Communicating and learning from patients: Patients’ Voice – Partially achieved**

The views of patients are an important measure in assessing the quality of care provided by staff. The Trust’s Patients’ Voice Survey, Friends and Family Test and the National Patient Satisfaction Surveys (A&E, Inpatients, children’s, maternity and Cancer) are pivotal in understanding what patients feel about the services we provide.

In addition we seek regular and real time feedback from patients and their representatives at the bi-monthly Patient Experience Panel. We actively engaging with the public to give feedback through representative groups such as; Lesbian, Gay, Bi-sexual and Transgender Health Improvement Partnership, Healthwatch, Speak Out (Learning Disability Advocacy) and the Carer’s Centre, this gives us the opportunity to obtain our patients’ views on the services we provide and also invites their input into service developments and improvements. For inpatients the Patients’ Voice survey has been adapted to incorporate the National Friends and Family Test (FFT). The FFT question of whether you (the patient) would recommend this hospital to a relative or friend is also asked in A&E, Children’s services, Day case and Out patients. Our Friends and Family Test scores are shown on page 47 of this report. In addition to improving our FFT scores in 2017/18 we will also be aiming to improve our response rates to the FFT survey.

Our Complaints and Patient Advice and Liaison Service (PALS) teams work closely together to identify emerging themes from the informal and formal concerns received. The teams work closely with the specialties to ensure that lessons are quickly learnt from any reported poor patient experience.

The national survey of in-patients carried out in August 2016 showed significant improvement in the following areas:

- Patients having confidence and trust in nursing staff
- Patients knowing which nurse was in charge of care
- Nurses answering call buttons promptly
- Discharges being delayed by an hour or more
- And overall patients feeling well looked after by staff

Our focus in 2017/18 will be to reduce mixed sex accommodation breaches; improve food quality and assistance at mealtimes; provide better information for patients regarding their procedure and operations; and improving discharge planning. Improvements will be monitored through our revised patient experience governance arrangements.

BSUH is fortunate to have active feedback and direct support from a range of patient organisations. As the official Health and Care Watchdog Healthwatch Brighton and Hove has been actively supporting the Trust to improve quality and safety. Healthwatch projects and reports reflect patient experiences in a very direct way and we work closely with the Care Quality Commission [CQC] regulators.

‘Brighton Pulse’ is the online feedback centre for Healthwatch locally and provides an easy way for patients, relatives and staff to report...
Part 3

their experiences and help to make changes and improve quality and safety.

Across all the Healthwatch activities that support BSUH we estimate that Healthwatch Brighton and Hove have contributed more than 1,600 hours of volunteer time to BSUH in 2016/17.

Improving the prevention of pressure damage – Not achieved

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

A reduction of 10% was set as a target for 2016-17, this equates to a pressure damage rate of 0.41 incidents per 1000 bed stay days. Like the inpatient falls initiative it was recognised that this was an ambitious target given that the rate of pressure damage has come down from 1.49 incidents in 2010-11. This year’s target was missed as the rate returned was 0.52 or 11% higher than 2015-16.

Plan for 2017-18

In the absence of any significant reduction over the past four years are aim for the forthcoming year is to sustain the pressure damage rate. Although this project we not be carried forward as a 2017-18 priority the pressure damage rate will continue to be monitored at the Trusts Safety and Quality Committee.

Towards a more engaged workforce (Innovation Forum) – Achieved

Anyone who has ever worked in any organisation will know that the people doing the job on the frontline day in and day out are the ones who really know what happens, what is done well, and what can be done better. Members of staff are often put off from making any improvements simply because they don’t know how to make the change, or don’t believe they will be listened to by the people at the top.

In October 2012, the Innovation Forum (IF) was launched as a means of encouraging and enabling grassroots innovation. IF is a platform where anyone and everyone working at the Trust can voice their own ideas on the changes and improvements they see necessary. IF is set up to facilitate access to the right people, networks, and resources. Through IF, staff members are able to retain responsibility and ownership of their ideas and take the lead on their own innovative projects.

The ambition for 2016-17 was to continue to run four innovation forums during the year. Following a rebranding in March 2016 the IF Steering Group planned to continue its efforts to raise the

![Pressure Damage Rate per 1000 bed stay days](image-url)
profile of the forum with the target of receiving over ten submissions from professional groups across the organisation.

Four Innovation forum events have been held this year and the first date for 2017-18 are scheduled. New formats have been trialled including two lunchtime meetings and the first event at PRH as well as a new ‘quick fire’ round to generate ideas have been very successful. Attracting submissions and attendance from non-medical staff groups remains challenging, but is steadily improving. The Steering Group meet regularly to plan the events and have been joined recently by Mr Tony Miles who has a wealth of experience in Innovation and Improvement.

Whilst the events themselves are successful, the Steering Group acknowledges that we have room for improvement in the on-going support and encouragement that we offer to presenters after the event. The Steering Group intends to work on this going forward for 2017/18 and form stronger links with other Innovation/Improvement activity within the Trust, and form a database of interested individuals across different areas that can help progress ideas and realise the ambitions of innovators.

Reducing hospital acquired infection – Not achieved

Infection prevention is vital in ensuring patient safety, preventing harm, delivering good outcomes, maintaining the Trust’s reputation and the public’s confidence. Over recent years the Trust has made significant progress with a year-on-year reduction on both Methicillin resistance Staphylococcus aureus (MRSA) and Clostridium difficile infections.

The target for MRSA bacteraemia and Clostridium difficile infections is set nationally. For 2016/17 the Trust trajectory was:

- Zero avoidable MRSA bacteraemia
- No more than 46 Trust acquired cases of Clostridium difficile infection

The Trust has reported 51 cases of Trust acquired Clostridium difficile infection. The Trust saw a significant spike in Clostridium difficile infection in July and again in September 2016. Although the Trust has breached, an action plan was implemented and a significant amount of work has been undertaken across the Trust to enable us to demonstrate a downward trend since September 2016. The Trust has also experienced several periods of increased incidents of outbreaks of Norovirus and Influenza; and these have had a significant impact on the Trust bed capacity and patient flow. A root cause analysis (RCA) is undertaken for every Trust acquired Clostridium difficile infection, which were presented to the RCA review group, Clinical Governance and the CCG. Control measures were implemented, reviewed and monitored throughout the periods of increased incidents and outbreaks so that the spread was minimised where possible to ensure the safety of patients, visitors and staff.

The Trust has reported 3 cases of Trust acquired MRSA bacteraemia. The first case was acquired in October 2016, the second in January 2017. A Post Infection Review (PIR) was conducted for both cases, which were presented to the RCA review group and Clinical Governance. Control measures were implemented, reviewed and monitored for each case. The Trust has shared learning and outcomes through various collaborative forums including the Public Health England Healthcare Association Infection Capture Database, NHS Improvement, CCG, and Clinical Governance.

Plan for 2017-18

The 2017-18 target remains the same at:

- Zero avoidable MRSA bacteraemia
- No more than 46 Trust acquired cases of Clostridium difficile infection
Part 3

Performance against the 2016/17 core set of indicators

Summary Hospital-Level Mortality Indicator

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

<table>
<thead>
<tr>
<th>SHMI</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH rate</td>
<td>0.9465</td>
<td>0.9400</td>
</tr>
<tr>
<td>National average</td>
<td>1.0000</td>
<td>1.0000</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>0.7547</td>
<td>0.7383</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>1.1857</td>
<td>1.1130</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described because it is taken from the national dataset. The Trust has taken actions to improve this rate, and so the safety of its services, by routinely monitoring mortality rates at the Trust Mortality Review Group. This includes looking at mortality rates by speciality, diagnosis and procedure. A systematic approach is adopted whenever an early warning of a problem is detected and the Patient Safety Committee and Board Quality and Performance Committee routinely scrutinises this data and receive six monthly reports on any concerns identified. This work is supported by our Coding Department to ensure any clinical and non-clinical concerns are identified. The Trust will fully implement the Learning from Deaths report recommendations in 2017/17.
Patient Reported Outcome Measures (PROMs)

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(i)</td>
<td>(ii)</td>
</tr>
<tr>
<td>BSUH rate</td>
<td>0.088</td>
<td>0.097</td>
</tr>
<tr>
<td>National average</td>
<td>0.084</td>
<td>0.095</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>0.102</td>
<td>0.127</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>0.027</td>
<td>-0.002</td>
</tr>
</tbody>
</table>

The Trust considers this data is as described because it has been taken from a national data set and the Trust’s participation rate is high, meaning that the data are reliable. The Trust’s PROMs for groin hernia surgery is lower than the national average and varicose vein surgery higher than the national average. The hip and knee replacement PROMs are broadly comparable to the national average and have improved from the previous year. The Trust will continue to keep the PROMs scores under review.

Patients readmitted to a hospital

The percentage of patients readmitted to a hospital within 30 days of discharge during the reporting period: (i) age 0-17; (ii) age 18-64.

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(i)</td>
</tr>
<tr>
<td>BSUH rate</td>
<td>10.2%</td>
</tr>
<tr>
<td>National average</td>
<td>Not available</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>Not available</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>Not available</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described because it taken from the national dataset. The Trust carried out an audit of re-admissions in 2016/17 which identified no significant concerns. The Trust will carry out a further audit in 2017/18.
Part 3

Responsiveness to the personal needs of patients

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH rate</td>
<td>69.2</td>
<td>68.7</td>
</tr>
<tr>
<td>National average</td>
<td>68.9</td>
<td>69.6</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>76.8</td>
<td>76.1</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>63.7</td>
<td>64.5</td>
</tr>
</tbody>
</table>

The Trust considers this data is as described because it is produced by the Picker Institute in accordance with strict criteria. An action plan that addresses the issues raised in the National Patient Survey has been developed and will focus on improvements in food, mixed sex accommodation, discharge planning and information for patients about their procedures.

Patients who would recommend the Trust to their family or friends

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>i</td>
<td>ii</td>
</tr>
<tr>
<td>BSUH rate</td>
<td>94.3</td>
<td>88.6</td>
</tr>
<tr>
<td>National average</td>
<td>95.3</td>
<td>87.4</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>98.3</td>
<td>96.2</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>88.2</td>
<td>70.3</td>
</tr>
</tbody>
</table>

The Trust considers this data is as described because we have developed a systematic approach to the collection of the Friends and Family Test scores. However we plan to improve our response rates to the FFT surveys in 2017/18.
Staff who would recommend the Trust to their friends and family

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH rate</td>
<td>69.0</td>
<td>55</td>
</tr>
<tr>
<td>National average</td>
<td>82.6</td>
<td>69</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>96.4</td>
<td>85</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>69.0</td>
<td>55</td>
</tr>
</tbody>
</table>

We consider this data is as described because the exercise is undertaken by an external organisation with adherence to strict protocols around sample size and selection. Improving staff experience and engagement is 1 of the 5 key objectives of the new Trust leadership team in 2017/18.

Patients admitted to hospital who were risk assessed for venous thromboembolism

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH rate</td>
<td>83.7%</td>
<td>92.34%</td>
</tr>
<tr>
<td>National average</td>
<td>95.7%</td>
<td>95.64%</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>Not available</td>
<td>100%</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>Not available</td>
<td>81.49%</td>
</tr>
</tbody>
</table>

The Trust considers the data is as described because it is routinely scrutinised at the monthly Patient Safety Committee. Further work will be undertaken to improve the data capture of VTE risk assessments.
Part 3

Rate of C. difficile infection

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 during the reporting period. Comparative data is benchmarked against non-specialist university hospitals that are members of The Association of UK University Hospitals.

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH rate</td>
<td>17.42</td>
<td>18.11</td>
</tr>
<tr>
<td>National average</td>
<td>17.63</td>
<td>15.22</td>
</tr>
<tr>
<td>Best performing teaching hospital</td>
<td>6.78</td>
<td>4.24</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>34.15</td>
<td>35.78</td>
</tr>
</tbody>
</table>

The Trust considers this data is as described because every case is scrutinised weekly by the Trust’s Infection Prevention and Control Action Group and reported externally. While the Trust’s rate is higher than the national average, there has been a year-on-year reduction. There will be a continuing focus on hand hygiene practice and anti-microbial stewardship in 2017/18.

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

The number and rate of patient safety incidents that occurred within the Trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death: i) rate of incidents reported per 1000 bed days  ii) rate of incidents 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. Comparative data is benchmarked against non-specialist university hospitals that are members of The Association of UK University Hospitals.

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH rate</td>
<td>29.94</td>
<td>0.047</td>
</tr>
<tr>
<td>National average</td>
<td>38.78</td>
<td>0.122</td>
</tr>
<tr>
<td>Best* performing teaching hospital</td>
<td>22.57</td>
<td>0.047</td>
</tr>
<tr>
<td>Worst performing teaching hospital</td>
<td>61.94</td>
<td>0.329</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described because a panel of consultants reviews this data weekly in order to ensure every incident is appropriately graded. The data is derived from the National Reporting and Learning System for patient safety incidents. Reported patient safety incidents increased by 20% in 2016/17 and the Trust will continue to improve its reporting culture and learning from incidents.
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.
Best of BSUH

Family thanks outstanding staff
A family who devastatingly lost two babies to an extremely rare lung condition have praised the “outstanding” staff who saved their son’s life. Sean and Sophie’s eldest daughters were both treated in the Trevor Mann Baby Unit (TMBU) after being born prematurely. They then had the heartbreak of losing two children in the space of nine months due to severe lung damage. The couple’s worst fears came true when their son Buzby was diagnosed with the same condition last year at just three days old, but TMBU staff saved him and he is well on the way to making a full recovery.

National recognition
A pioneering initiative to support trainee doctors and benefit patients has been shortlisted for a Health Service Journal Value in Healthcare Award. Specially selected Healthcare Assistants are now supporting trainee doctors with paperwork and routine clinical tasks such as taking blood and inserting cannulas. The project has been praised for improving services for patients, easing the pressure on junior doctors and providing experience and career development opportunities for healthcare workers.

Cardiac Rehabilitation Team wins gold
The BSUH cardiac rehabilitation team were awarded the gold standard by the British Association of Cardiovascular Prevention and Rehabilitation – one of only 14 out of 300 services in the country to receive this.
Midwife gets Royal approval

Mitch Denny, a BSUH midwife who provides specialist support to pregnant teenagers, was recognised for the support she provided to one young mum at an event to mark World Mental Health Day hosted by the Duke and Duchess of Cambridge and Prince Harry. The young royals were launching their “Heads Together” campaign at an exclusive event where they met young people who have struggled with mental health issues and the people who have supported them.

Call the Midwife writer opens new midwifery hub

Co-writer of the hit BBC One show Call the Midwife opened BSUH’s new Midwifery Hub in Hove and told those assembled how the hub had already helped her and her partner before and after the birth of their baby Greta. The hub is the first of its kind in the South East and will see up to 1,000 women each year for their ante and post natal care in an environment which is designed to be comfortable and calm.

Dame Judi Dench opens Park Radiotherapy Centre

The Sussex Cancer Centre at BSUH cares for cancer patients from across Sussex providing more than 17,000 oncology outpatient appointments, 9,000 chemotherapy episodes and 33,000 radiotherapy treatments every year. The Park Radiotherapy Centre, with its modern equipment and new facilities, is part of a plan to increase the availability of radiotherapy across Sussex, so that patients have shorter journeys during this critical time in their treatment. The new Centre was officially opened by star of the stage and screen Dame Judi Dench in June 2016.
Part 3

Statements from partners

East Sussex Health Overview and Scrutiny Committee (HOSC)

We agreed to co-ordinate with neighbouring HOSCs ongoing scrutiny of BSUH’s response to the August 2016 CQC report and its Quality Improvement Plan (QIP) via a joint liaison meeting.

During 2016/17 the Committee has welcomed BSUH’s positive engagement with all three Sussex HOSCs at these meetings. We feel that they offer a regular opportunity for Committee Members to raise issues and receive updates on the progress of the Trust's QIP. The Trust’s commitment to this engagement has been evidenced through the senior representation at meetings.

Despite the positive steps to engage with HOSC and evidence of improvement, we nevertheless remain concerned about the inadequate rating BSUH received from the CQC in August and would expect to see the new executive team making significant improvements this year, and for the foreseeable future, particularly regarding cultural and leadership issues, outpatient services, and emergency care.

2016/17 Quality Priorities

Given the scale of challenges facing the Trust during 2016/17 it is perhaps understandable that most priorities were partially achieved.

2017/18 Quality Priorities

We are glad to see the inclusion of improving patient experience in the Urgent Care Centre as one of the 2017/18 Quality Priorities. We would hope to see improvements to emergency care as a result, particularly given the serious concerns about the service expressed by the CQC.

Brighton and Hove Health Watch

We are aware from our intensive work with the BSUH over the last year that there has been a concerted effort to make improvements for patients, for example, the substantial reduction in the backlog of patients waiting for treatment. It is however, disappointing that in many areas targets are still not being met, for instance waiting times in Accident & Emergency, for cancer treatment and ‘referral to treatments’ times in some disciplines.

It is reassuring that actions plans and corrective action are in place including the challenges in staff turnover, staff vacancy rates and shortages in Consultant staff.

Healthwatch are concerned that the proportion of staff who would recommend BSUH hospitals to their friends and families is lower than the national average. We hope the Patient Engagement Panel can encourage staff to change their mind?

Healthwatch activities supporting BSUH in the last year have included (https://www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports/2016-reports/)

• In partnership with BSUH Co-Chairing and redesigning the Patient Experience Panel (PEP)
• Establishing separate PEP’s for the RSCH and Princess Royal Hospital and making it easier for Healthwatch East and West Sussex to be involved alongside a wide range of people who can meaningfully represent the patients voice
• We interviewed 32 patients at the RSCH Emergency Department and made a series of observational visits – our report was used as evidence by the Care Quality Commission
• We interviewed 117 patients using Out Patient Departments, provided seven detailed reports and recommendations for quality improvement.

• Healthwatch provide a monthly independent review of the physical environment in the hospital – a ‘spot check’ from the consumer’s eye view.

• We also provide volunteers to help with the annual PLACE reviews that also focus on the physical environment at BSUH hospitals, and assist with ‘mock’ CQC reviews.

• Healthwatch interviewed 60 renal dialysis patients using patient transport services PTS (BSUH do not commission or provide the PTS services). These transport services significantly impact patient experience and the capacity of hospital staff to deliver a quality experience. Our subsequent report contributed to substantial changes being made in this service.

• Healthwatch volunteers provide a ‘peer review’ of complaints made to BSUH. That is an independent quality check on how BSUH responds to complaints.

• IMPETUS (a local voluntary organisation) in partnership with Healthwatch provide an Independent Health Complaints Advocacy Service and that has helped some BSUH patients in the last year.

Across all the Healthwatch activities that support BSUH we estimate that Healthwatch Brighton and Hove have contributed more than 1,600 hours of volunteer time to BSUH in 2016/17.

We know that Healthwatch recommendations have been included in quality and safety improvement plans. Our Outpatient work identified the stress that delays in appointments issues with the Booking Hub were having on patients and we are pleased to see that this is a key priority in the QA for next year. Plans for further improvements in the operation of the Booking Hub have been reported in detail to the PEP who will be able to monitor progress for the patient perspective.

We are pleased that the recommendations in our A&E report of May 2016 about the urgent care centre have been taken on board and we look forward to seeing the new department.

David Liley
CEO
Healthwatch Brighton and Hove
22 June 2017
Brighton and Hove Clinical Commissioning Group

Thank you for giving the Sussex CCGs; Brighton and Hove, Crawley, Horsham and Mid-Sussex, High Weald Lewes and Havens, Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs, the opportunity to comment on your Quality Account for 2016/17.

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.

As the lead commissioner for Brighton and Sussex University Hospitals NHS Trust, we would like to acknowledge the work undertaken following the Care Quality Commission inspection in April 2016 resulting in the organisation being rated as inadequate overall and placed in special measurers by the NHSI. We fully appreciate the impact this has had on frontline staff and recognise the efforts of your hard working staff to continue to provide safe and effective care under extreme pressure.

We note the Trust’s commitment to improvement methodology with the launch of the Improvement Academy, empowering clinical teams to make changes and involving patients in this work. We are also pleased to see the continuing commitment to participation in clinical research in order to inform the delivery of patient services locally and as a participant to the to the wider improvement agenda across the NHS.

Commissioners support your commitment to improve data quality in 17/18 ensuring regular validation of waiting list supporting the timely management of issues and potential delays.

We would also wish to recognise the work of the Royal Alexandra Children’s Hospital which was identified for their work with Children and Young People as Outstanding by the CQC, and the recognition in 2016 of Mitch Denny and her work with pregnant teenagers.

We recognise that the organisation is starting 2017/18 with a new management team and the challenge but also opportunities that the extensive redevelopment of the Royal Sussex University Hospital site brings. The work ahead cannot be underestimated but we feel confident that the commitment and energy demonstrated to date to improve patient service and increasingly work in partnership with system partners and stakeholders will continue.

The commissioners endorse this Quality Account for 2017/18 and we look forward to continuing our good relationships so we can all drive forward the quality improvements for our local populations.

Adam Doyle
Chief Accountable Officer
NHS Brighton & Hove Clinical Commissioning Group
22 June 2017
Part 4

Directors’ responsibilities

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

• The Quality Account presents a balanced picture of the Trust’s performance over the period covered;

• The performance information reported in the Quality Account is reliable and accurate;

• There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

• The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account. The content of this report and our quality improvement priorities were agreed by the Board of Directors.

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

Marianne Griffiths
Chief Executive

Mike Viggers
Chairman
Auditors’ report

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

We are required to perform an independent assurance engagement in respect of Brighton and Sussex University Hospitals NHS Trust’s Quality Account for the year ended 31 March 2017 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2017 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 auditors
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:
• the Quality Account presents a balanced picture of the trust’s performance over the period covered;
• the performance information reported in the Quality Account is reliable and accurate;
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
• the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
• the Quality Account has been prepared in accordance with Department of Health guidance.

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

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
• the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices 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:
- Board minutes for the period April 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from the Commissioners dated June 2017;
- feedback from Local Healthwatch dated June 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 for 2017
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey dated September 2016;
- the latest national staff survey for 2016;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017
- the Annual Governance Statement dated 31 May 2017;
- the Care Quality Commission's quality and risk profiles dated 17 August 2016

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

This report, including the conclusion, is made solely to the Board of Directors of Brighton and Sussex University Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Brighton and Sussex University Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:
- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

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

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

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Brighton and Sussex University Hospitals NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

The maintenance and integrity of the Brighton and Sussex University Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the Quality Accounts since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of the Quality Accounts may differ from legislation in other jurisdictions.

Ernst & Young LLP
Southampton
30 June 2017
Glossary of terms and acronyms

**Accident and Emergency (A&E) Service**
A responsive service for patients in an emergency situation with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

**ABI** Acute Brain Injury.

**ACU** Ambulatory Care Unit.

**Allied Health Professionals (AHP)**
Allied Health Professionals (such as Physiotherapists, Occupational Therapists, Speech and Language Therapists, Podiatrists) provide treatment and help rehabilitate adults and children who are ill, have disabilities or special needs, to live life as fully as possible. They often manage their own caseloads.

**Advanced Medical Priority Dispatch System (AMPDS)**
An international system that prioritises 999 calls using information about the patient as supplied by the caller.

**Ambulance Quality Indicators (AQIs)**
AQIs were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance specific and are concerned with patient safety and outcomes.

**Any Qualified Provider (AQP)**
When a service is opened up to choice of ‘Any Qualified Provider’, patients can choose from a range of providers, all of whom meet NHS standards and price.

**Ambulance Service Cardiovascular Quality Initiative**
The initiative aims to improve the delivery of pre-hospital (ambulance service) care for cardiovascular disease to improve services for people with heart attack and stroke.

**AMU** Acute Medical Unit.

**Annual Assurance Statement**
The means by which the Accountable Officer declares his or her approach to, and responsibility for, risk management, internal control and corporate governance. It is also the vehicle for highlighting weaknesses which exist in the internal control system within the organisation. It forms part of the Annual Report and Accounts.

**Automated External Defibrillator (AED)**
A portable device used to restart a heart that has stopped.

**Bare Below the Elbows**
An NHS dress code to help with infection, prevention and control.

**BAU** Business as usual.

**Better Payment Practice Code (BPPC)**
The BPPC was established to promote a better payment culture within the UK and urges all organisations to adopt a responsible attitude to paying on time. The target is to pay all invoices within 30 days of receipt.

**BGH** Brighton General Hospital.

**Board Assurance Framework (BAF)**
The Board Assurance Framework provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps.

**Board Governance Assurance Framework (BGAF)**
The Board Governance Assurance Framework assists Boards through a combination of self and independent assessment processes to ensure they are appropriately skilled and prepared to achieve FT authorisation.
British Association for Immediate Care (BASICS)
A network of doctors who provide support to ambulance crews at serious road traffic collisions and other trauma incidents across the region.

British National Formulary (BNF)
The British National Formulary provides UK healthcare professionals with authoritative and practical information on the selection and clinical use of medicines in a clear, concise and accessible manner.

Bronze Commander Training
A course designed to develop and equip ambulance services, health colleagues and Voluntary Aid Society Incident Managers at operational/bronze level to effectively manage major/catastrophic incidents.

BSMS Brighton and Sussex Medical School.

Caldicott Guardian
A senior member of staff appointed to protect patient information.

CAMHS Child and Adult Mental Health Service.

CAPEX Capital Expenditure.

Cardio-pulmonary Resuscitation (CPR)
A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.

Care Bundle
A care bundle is a group of interventions (practices) related to a disease process that, when carried out together, result in better outcomes than when implemented individually.

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

Catheter-acquired Urinary Tract Infection (CAUTI)
A bladder infection that has occurred as a direct result of the presence of an indwelling catheter (a mechanism used initially to help the bladder).

Central Sterile Service Department (CSSD)
A service that provides equipment sterilisation services.

Centre for Maternal And Child Enquiries (CMACE)
Aims to improve the health of mothers, babies and children by carrying out confidential enquiries and related work on a nationwide basis.

Chartered Society of Physiotherapy (CSP)
The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK’s 50,000 chartered physiotherapists, physiotherapy students and support workers.

Chairman
The Chairman provides leadership to the Trust Board and chairs all Board meetings. The Chairman ensures key and appropriate issues are discussed by the executive and nonexecutive directors.

Chief Executive
The highest-ranking officer in the Trust, who is the Accountable Officer responsible to the Department of Health for the activities of the organisation.

Chronic Obstructive Pulmonary Disease (COPD)
Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases, including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have trouble breathing in and out. This is referred to as airflow obstruction.

CIRU Clinical Investigation and Research Unit.

Clinical Commissioning Groups (CCGs)
Clinical Commissioning Groups replaced primary care trusts in April 2013; they are responsible for planning and designing local health services in England. They do this by ‘commissioning’ or buying health and care services.
Clinical Hub
A team of clinical advisors based within the Emergency Operations Centres providing support for patients with non-life threatening conditions.

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

Clinical Performance Indicators (CPIs)
CPIs were developed by ambulance clinicians and are used nationally to measure the quality of important areas of clinical care. They are designed to support the clinical care we provide to patients by auditing what we do.

Clinical Supervisor
Works on the frontline as part of the operational management team and facilitates the development of clinical staff and helps them to practise safely and effectively by carrying out regular assessment and revalidations.

CLN Community Link Nurse.

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.

CNS Central Nervous System.

Community Alcohol and Drug Service (CADS)
The main aim of the service is to reduce problems related to drugs and alcohol misuse, and support recovery. In order to do this CADS provides a range of modalities including advice and information, community and specialist prescribing, structured psychosocial interventions, structured treatments, harm reduction interventions and aftercare.

Community Equipment Store (CES)
This service provides all types of equipment to patients who are managed at home or in care homes, e.g. hospital beds, mattresses, commodes, toilet raisers, chair raisers and Telehealth systems.

Community First Responders (CFRs)
Volunteers in their local communities, who respond from their home addresses or places of work to patients suffering life-threatening emergencies.

Community Nursing and Therapy (CN&T)
Home delivered nursing, therapy services and interventions for Adults, such as wound dressings, end of life care and rehabilitation programmes.

Comprehensive Local Research Networks (CLRNs)
Coordinate and facilitate the conduct of clinical research and provide a wide range of support to the local research community.

Computer Aided Dispatch (CAD)
A method of dispatching ambulance resources.

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

Corporate Risk Register (CRR)
The Corporate Risk Register is the aggregation of the local team and corporate department risk registers where the residual risk is more than 12. It includes any additional sources of risk such as external or internal reviews.

Cost Improvement Plan / Programme (CIP)
The formal identification of an action which reduces the budgeted cost base of the organisation. It can relate to either pay or non-pay costs.
COTE Care of The Elderly.

CSIC Cancer Support and Information Centre

CT Computed Tomography

DASH Disability and Specialist Health Pathway.

Data Protection Act 1998 (DPA)
The Data Protection Act 1998 requires every organisation processing personal data to register with the Information Commissioner’s Office, unless they are exempt.

Datix
A paperless risk management monitoring tool that aids staff in the reporting and management of incidents and risks.

DDA Disability Discrimination Act.

Department of Health (DH)
The government department which provides strategic leadership for public health, the NHS and social care in England.

Deprivation of Liberty (DoL)
DoL originates from case law rather than definitive acts of parliament. However, under the Mental Capacity Act (MCA) it is now clear that someone cannot be made to do something that they are resisting and a full assessment should be made to enable decisions to deprive someone from a liberty for their own safety or well-being.

Electrocardiograms (ECG)
An interpretation of the electrical activity of the heart. This is done by attaching electrodes to the patient which record the activity of the different sections of the heart.

Electroencephalogram (EEG)
An electroencephalogram is a recording of brain activity.

Emergency Department (ED)
A hospital department responsible for assessing and treating patients with serious injuries or illnesses.

Emergency Preparedness, Resilience and Response (EPRR)
In April 2013, NHS England introduced the EPRR Core Standards detailing the roles and responsibilities involved in EPRR, Major Incident and Service Continuity planning, partnership working, resource allocation and staff competencies.

ENT Ear, Nose and Throat.

Equality and Diversity
Equality legislation protects people from being discriminated against on the grounds of their sex, race, disability, etc. Diversity is about respecting individual differences such as race, culture, political views, religious views, gender, age, etc.

EVAR Endovascular Aneurysm Repair.

FEVAR Fenestrated Endovascular Aortic Aneurysm Repair

FM Facilities Management.

Freedom of Information (FOI) Act 2000
The Freedom of Information Act 2000 is an Act of Parliament that creates a public ‘right of access to information held by public authorities.

FTT Family and Friends Test.

Foundation Trust (FT)
NHS organisations which operate more independently under a different governance and financial framework.

Foundation Trust Network (FTN)
The Foundation Trust Network is the membership organisation for NHS public provider trusts. It represents every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts. Members provide the full range of NHS services in hospitals, the community and at home.

General Practitioner (GP)
A doctor who is based in the community and manages all aspects of family health.
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.

GUM Genito-Urinary Medicine.

Hazardous Area Response Team (HART)
A group of staff who are trained to deliver ambulance services under specific circumstances, such as at height or underground.

HCA Health Care Assistant.

HDU High Dependency Unit.

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

Human Resources (HR)
A function with responsibility for implementing strategies and policies relating to the management of individuals.

ICU Intensive Care Unit.

Independent Mental Capacity Advocate (IMCA)
A service introduced by the MCA 2005 that helps particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions.

IM&T Information Management and Technology

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. Governance Toolkit assessments.

Institute of Healthcare and Development (IHCD)
A body responsible for the content of some ambulance staff training which is then delivered through ambulance trusts.

Integrated Business Plan (IBP)
An IBP sets out an organisation’s vision and plans to achieve that vision in the future.

Integrated Performance Report (IPR)
A report used to assure the Trust Board of organisational performance; to flag exceptions to the achievement of performance standards and corrective action as appropriate.

International Normalised Ratio (INR)
A laboratory measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants (an anticoagulant is a substance that prevents clotting of blood) on the clotting system.

ISO International Standards Organisation.

ITU Intensive Therapy Unit.

Key Performance Indicator (KPI)
A measure of performance.

Knowledge and Skills Framework (KSF)
A competence framework to support personal development and career progression within the NHS.

Learning Disability (LD)
A learning disability affects the way a person learns new things in any area of life. It affects the way they understand information and how they communicate.
Local Involvement Network (LINk)
A network of individuals and community groups, such as faith groups and residents’ associations, working together to improve health and social care services. A new consumer champion called Healthwatch has started to replace LINks from October 2012.

LPA Local Planning Authority.

Major Trauma
Major trauma is serious injury and generally includes such injuries as traumatic injury requiring amputation of a limb; major head injury; multiple injuries to different parts of the body; spinal injury; and severe burns.

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

Malnutrition Universal Screening Tool (MUST)
A five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan.

Mental Capacity Act (MCA)
Legislation designed to protect and empower people who cannot make decisions for themselves or lack the mental capacity to do so. The Act states that: you should have as much help as possible to make your own decisions; people should assess if you can make a particular decision; even if you cannot make a complicated decision for yourself, this does not mean that you cannot make more straightforward decisions; even if someone has to make a decision on your behalf you must still be involved in this as much as possible; anyone making a decision on your behalf must do so in your best interests. MCA often applies to people with a learning disability, dementia, mental health problem, brain injury or stroke.

Methicillin-resistant Staphylococcus Aureus (MRSA)
A bacterium responsible for several difficult-to-treat infections in humans due to its resistance to methicillin and other beta-lactam antibiotics.

Monitor
The independent regulator of NHS foundation trusts.

MRI Magnentic Resonance Imaging.

Myocardial Infarction (MI)
Commonly known as a heart attack, an MI is the interruption of blood supply to part of the heart, causing heart cells to die.

Myocardial Ischemia National Audit Project (MINAP)
A national database gathering information on all patients who have had a heart attack or who have acute coronary syndromes.

National Early Warning Score (NEWS)
NEWS is designed to capture and bring together all of the factors that could impact on the quality and safety of clinical services; to identify services that may be at risk and to help prevent serious

NHSLA Risk Management Standards for Ambulance Trusts
Ambulance trusts are assessed against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.

National Infarct Angioplasty Project (NIAP)
An audit of patients referred for an angioplasty surgical procedure.

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 Learning Management System (NLMS)
Provides NHS staff with access to a wide range of national and local NHS eLearning courses, as well as access to an individual’s full training history.

National Patient Safety Agency (NPSA)
The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

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.

Net Promoter Score (NPS)
The net promoter score is a key measure of individual, team and corporate performance and is used to drive up positive patient experience.

NHS Commissioning Board
Formally established as an independent body on 1 October 2012, the NHS Commissioning Board is responsible for authorising Clinical Commissioning Groups (CCGs), working collaboratively with partners and encouraging patient and public participation in the NHS.

NHS Property Services (Prop Co)
A Government-owned limited company that will take ownership of, and manage, that part of the existing primary care trust estate that will not transfer to NHS community care providers under the healthcare reform plans set out in the Health and Social Care Bill.

Non-Executive Director (NED)
A Non-Executive Director is a member of the Board of Directors, drawn from the local community, and appointed by the Trust Development Authority. NEDs hold the Executive Directors to account.

OPD Out-patients Department.

OT Occupational Therapy.

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

PACS Picture Archiving and Communications System.

Paramedic
Senior ambulance service healthcare professionals at an accident or medical emergency. Working alone or with an assistant practitioner or emergency care technician, they assess a patient’s condition and provide essential treatment.

Paramedic Practitioner
Paramedic practitioners come from a paramedic background and have additional training in injury assessment and diagnostic abilities.

Patient Administration System (PAS)
An information collection system that acute and community hospitals use to collect patient related data.

Patient Advice and Liaison Service (PALS)
The Patient Advice and Liaison Service assists patients, their relatives, carers and friends, answering questions and resolving concerns as quickly as possible.

Patient-Led Assessments of the Care Environment (PLACE)
The Patient-Led Assessments of the Care Environment (PLACE) programme replaced the former Patient Environment Action Team (PEAT) programme from April 2013. These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors).

Patient Report Form (PRF)
A comprehensive record of the care provided to patients.
Patient Transport Service (PTS)
A non-emergency medical transport service used, for example, to and from out-patient appointments.

PEAT Patient Environment Action Team

Personal Development Reviews (PDRs)
The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.

Personal Digital Assistants (PDAs)
Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.

PICU Paediatric Intensive Care Unit.

PGMC Post Graduate Medical Centre.

PPM Planned Preventative Maintenance.

PPU Private Patients Unit.

PRH Princess Royal Hospital.

Primary Care Trust (PCT)
PCTs worked with local authorities and other agencies providing health and social care locally to ensure community health needs were being met. They were replaced by Clinical Commissioning Groups (CCGs) in April 2013.

Primary Percutaneous Coronary Intervention (pPCI)
A surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart. QGAF Quality Governance Assurance Framework.

Quality Innovation, Productivity and Prevention
A large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. It will improve the quality.

RACH Royal Alexandra Children’s Hospital.

Rapid Response Vehicle (RRV)
A car operated by the ambulance service to respond to medical emergencies either in addition to, or in place of, an ambulance capable of transporting patients.

Rapid Access Team (RAT)
A team of nurses, therapists and social workers who respond quickly to patients who are admitted to accident and emergency to find alternative solutions to enable patients to be cared for at home.

RACOP Rapid Assessment Clinic for Older People.

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.

Safety Thermometer
The NHS Safety Thermometer is a tool designed to help hospitals understand where they can potentially cause harm to patients and reduce the risk of this.

Serious Case Reviews (SCRs)
Establish whether there are any lessons to be learnt about the way in which staff and agencies work together to safeguard vulnerable people.

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.

SAU Surgical Assessment Unit.

Sexual Assault Referral Centre (SARC)
SARCs are specialist medical and forensic services for anyone who has been raped or sexually assaulted.
Stakeholders
All those who may use the service, be affected by or who should be involved in its operation.

ST Elevation Myocardial Infarction (STEMI)
A type of heart attack.

Strategic Health Authority (SHA)
NHS East of England is the regional headquarters of the NHS, and provides strategic leadership to all NHS organisations across the six counties. It is ultimately accountable to the Secretary of State for Health.

Serious Incident Requiring Investigation (SIRI)
The National Patient Safety Agency has developed a national framework for serious incidents in the NHS, entitled ‘National Framework for Reporting and Learning from Serious Incidents requiring Investigation’. An incident or event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in, for example, unexpected or avoidable death of one or more patients, staff, visitors or members of the public; serious harm to one or more patients, staff, visitors or members of the public.

Strategic Executive Information System (STEIS)
A system to collect data for the Department of Health.

SOP Standard Operating Procedure.

SSPAU Short Stay Paediatric Assessment Unit.

SystmOne
SystmOne is a centralised clinical system that provides healthcare professionals with a complete management system.

Trust Development Authority (TDA)
The NHS Trust Development Authority (TDA) is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers. This includes 99 NHS Trusts, providing around £30bn of NHS funded care each year. The TDA oversees the performance management of these NHS Trusts, ensuring they provide high quality sustainable services, and provides guidance and support on their journey to achieving Foundation Trust status.

To Take Out (TTO)
‘To take out’ is the literal meaning for the medications patients take home.

Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE)
The purpose of the Transfer of Undertakings (Protection of Employment) Regulations is to protect employees if ownership of their employer changes hands.

UCC Urgent Care Centre

Venous Thromboembolism (VTE)
A blood clot that forms within a vein.

Waterlow
The Waterlow pressure ulcer risk assessment/prevention policy tool is, by far, the most frequently used system in the UK and is also the most easily understood and used by nurses dealing directly