NHS
Brighton and Sussex University Hospitals NHS Trust

Quality Accounts 2020-21

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Part 1: Statement on Quality from the Chief Executive Officer

What we do

On 1st April 2021, Brighton and Sussex University Hospitals Trust (BSUH) merged with Western Sussex Hospitals NHS Foundation Trust (WSHFT) to form University Hospitals Sussex NHS Foundation Trust (UHSUSSEX).

Prior to 1st April 2021 BSUH was an acute teaching hospital working across two main sites: the Royal Sussex County Hospital (RSCH) in Brighton and the Princess Royal Hospital (PRH) in Haywards Heath. The Brighton campus also includes the Royal Alexandra Children's Hospital (RACH) and the Sussex Eye Hospital (SEH) and is the major trauma centre for the region.

BSUH provided 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 RSCH has a 24/7 Emergency Department (ED) for its local population and is also our centre for emergency and tertiary care. The PRH also has a 24/7 ED for its local population and is our centre for elective surgery.

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

BSUH worked in partnership with Brighton and Sussex Medical School, Health Education England, Kent, Surrey and Sussex Postgraduate Deanery and the Universities of Brighton and Sussex.

Purpose of the Quality Account

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

Statement on Quality from the Chief Executive Officer

Welcome to the 2020/2021 Quality Account for Brighton & Sussex University Hospitals

This document will review our progress over the last twelve months and forms part of a suite of legacy documents that have been developed for the organisation as we look forward to the next year as part of our new organisation, merged with Western Sussex Hospitals NHS Foundation Trust, to form University Hospitals Sussex NHS Foundation Trust.

I am hugely proud to be part of this organisation, as we continue to work with colleagues, determined to further improve the services we provide.

The year 2020/2021 will be remembered as a traumatic one for much of the world. In its 73 years, the NHS has never known anything like it. We have been tested as never before, as a National Health Service, as a Trust, and as individuals. Many families, and our own staff caring for the most unwell patients, will have been deeply affected by the impact of the pandemic.

Faced with this challenge, staff across the Trust have continued to demonstrate their compassion and courage, striving to innovate and improve quality.

This dedication has led to some significant achievements in the past year including the continued implementation of use of new technology to support quality and patient safety, improvement in the care of deteriorating patients and the increased implementation of Treatment Escalation Plans.

We were last inspected by the Care Quality Commission (CQC) in January of 2019, where we achieved a 'Good' overall rating with 'Outstanding' for caring, the inspection recognised the 'huge improvements' made at the Trust since its last inspection. Despite the impact of the pandemic, we are proud to have maintained many of the improvements over the last year and continue to build upon this success as we move into the new financial year and our new organisation.

Our Patient First programme is central to this progress, equipping staff to make improvements in line with our organisational priorities, something we describe as our True North. Despite the impact of COVID-19 the Trust sought to continue to capture the voices of patients and ensure that such feedback was intrinsic to improvement activities. Active engagement with patients, carers, community representatives and the public in how our services are planned, delivered and evaluated continues, as we strive to make co-design the norm.

Whilst we have seen improvement, as we move out of the pandemic, we still have a significant journey to make as we restore services and continue to meet with the challenges beyond Covid 19. Our Patient First approach, combined with the hard-work and dedication of our staff, means I am confident that we will make excellent progress through 2021 and beyond.

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

Dame Marianne Griffiths – Chief Executive.

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

2.1 Priorities for improvement in 2021/22

On 1st April 2021, Brighton and Sussex University Hospitals Trust (BSUH) merged with Western Sussex Hospitals NHS Foundation Trust (WSHFT) to form University Hospitals Sussex NHS Foundation Trust (UHSUSSEX). Therefore, this year's Quality Accounts has been written as a legacy document for BSUH, the sole purpose here is to summarise the previous year rather than to look forwards; the forward plan will be included in the newly merged UHSUSSEX Quality Account.

This year's Quality Accounts and quality improvement programme has for a second year been shaped by the Covid-19 pandemic. As discussed in last year's Quality Accounts because of the first wave of Covid-19 the plan of work for 2020-21 was based primarily on the Commissioning for Quality and Innovation (CQUIN) programme. The emphasis on CQUINs came about because the usual processes, discussions and collaborations that occur during a normal year were compromised during the first quarter of 2020 and this was compounded by the suspension of the Clinical Outcomes and Effectiveness Group (COEG) which would normally have responsibility for the development and approval of the Quality Accounts programme of work.

When last year's Quality Accounts were approved by the Board in June 2020 it was anticipated that the CQUINs programme would commence in the second quarter of 2020-21. However, the commencement of the programme did not materialise and is currently on-hold until the second quarter of 2021-22.

Initiatives that were outlined in last year's Quality Accounts were based on the Darzi framework in which quality includes the following aspects:

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

The cancellation of the February's COEG meeting curtailed discussions that had begun at the start of the year. Consequently, no explicit targets were set for the patient safety initiatives of falls and pressure ulcers, etc. Whilst no targets were established, falls and pressure ulcers were continually monitored and reviewed during the year, further information can be found in section 3.1 of this document.

The programme on falls, which is now in its 10th year, was recognised in a number of national publications during the past year – the British Journal of Nursing, NHE Digital and the Nursing Standard. During 2020-21 the adult inpatients falls rate was 3.71 falls per 1000 bed stay days,

which was marginally higher than the previous year's rate of 3.68. The last available national data for falls reported a rate of 6.6 falls per 1000 bed days.

The rate of acquired pressure ulcers was 1.09 per 1000 bed days, exactly the same rate as in 2019-20.

The other two ***Patient Safety*** initiatives planned last year were both CQUIN's projects:

- Supporting the anti-microbial resistance agenda by better targeting the usage of antifungals, and
- Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery.

It is anticipated that both these projects will commence latter in 2021.

Similarly, the two ***Patient Experience*** projects - finding patients who are living with Hepatitis C and cirrhosis and fibrosis tests for alcohol dependent patients are also scheduled to start in 2021.

Despite the impact of COVID-19 the trust sought to continue to capture the voices of patients and ensure that such feedback was intrinsic to improvement activities. Active engagement with patients, carers, community representatives and the public in how our services are planned, delivered and evaluated continues - making co-design the norm.

The COVID -19 pandemic required adaptive and intuitive responses and necessitated a shift in emphasis from responding to patient feedback to proactively creating positive experiences. A number of initiatives were quickly introduced to enable patients stay in contact with their families and loved ones.

As with the patient safety projects, whilst no explicit targets were set for the ***Effectiveness of Care*** initiatives, work continued on the sepsis, acute kidney injury (AKI) and 'improving the quality of care of people at the end of life' work stream's under the deteriorating patient programme umbrella. The reducing mortality programme of work also continued under the supervision of the Trust Wide Mortality Review Group (TMRG). Again, further information can be found in section 3.1 of this document.

Although standardised mortality ratio's like HSMR and SHMI are not designed to model pandemic activity, mortality rates have been continuously monitored during the past 12 months. A review of mortality in 2020 highlighted that:

- 1547 patients died in BSUH during 2020, of these 234 (15%) died within 28 days of having a positive swab for Covid-19
- The annual number of deaths in 2020 was lower than the previous five years with 53 fewer deaths in 2020 compared to 2019
- The number of deaths in March and April were higher than predicted and the rate of crude mortality was also higher in these months
- Deaths in July and October were lower than predicted
- The proportion of male deaths as a result of Covid-19 was statistically significantly high at 63%
- 65% of the Covid-19 deaths occurred in patients aged 80 or above, this compares to 55% of the non Covid-19 deaths
- In total 140 patients died in the first wave of Covid-19
- In the 12 months to December 20 the rolling SHMI was 108.3
- In the 12 months to January 21 the rolling HSMR was 96.3

Three new CQUIN projects were also included in the Effectiveness of Care programme, these were:

- Rapid rule out protocol for ED patients with suspected acute myocardial infraction,
- Appropriate antibiotic prescribing for urinary tract infections (UTI) in adults aged 16+.
- Treatment of community acquired pneumonia (CAP) in line with British Thoracic Society (BTS) care bundle.

Again it is anticipated that these will also commence at some point in 2021,

Getting it Right First Time (GIRFT)

The Getting it Right First Time (GIRFT) initiative continued intermittently during 2020-21 and has now undertaken a review in 28 clinical specialties in BSUH since January 2019.

Every review undertaken by GIRFT results in the development of an implementation plan. A paper presented to COEG summarised some of the main themes that have cut across clinical specialities. The most frequently noted theme in 17 of the reviews was the issue of service development and space, for example in the Emergency Department (ED) review, GIRFT commented on the ED estate in Brighton and Haywards Heath noting them both to be inadequate with insufficient clinical examination and treatment spaces for the volume of work and a resuscitation room that is too small for the task required of it.

Recruitment and extended roles were identified in 14 of the reviews, for example, in ophthalmology it was suggested that additional failsafe officers would also be beneficial in providing a safer service.

Pathways were cited in 13 reviews; in orthopaedic surgery referral to treatment (RTT) times were noted to be an average of 15 weeks, significantly higher than the England average of 8 weeks

Coding issues were also noted in 13 reviews, in lung cancer it was suggested that coding of oncology patients admitted with lung cancer should be explored as the identified number of 40 per annum appears disproportionately low.

Clinical audits were proposed in 12 reviews among the topics proposed was an audit in ophthalmology to determine whether day case patients who stay overnight are being kept in hospital for medical or social reasons.

National audit

Participation in national audits enables trusts and services to measure the performance of their own services against those of others elsewhere across the country. Many national audits produce a summary report with recommendations that can be used by trusts to develop their own action plans for improvement.

Trusts are not necessarily expected to participate in all national audits, however, each year NHS England publish a list of national audits where involvement is mandatory.

Participation in mandatory national audits has been good, in 2019/20, the participation rate reached 100% for this first time.

As with GIRFT, Covid-19 has also impacted on the National Audit programme, with a number of audits temporarily suspended, in order to ensure that frontline staff would not be diverted away from providing essential care. There were exceptions for those audits that were deemed highly relevant in providing useful data during the surge period, e.g. the Intensive Care National Audit and Research Centre (INARC) Case Mix Programme, which runs in critical care units. In these cases, trusts were encouraged to continue to submit data.

While many non- National Clinical Audit and Patient Outcomes Programme (NCAPOP) national audits have been suspended due to COVID, trusts have been encouraged to continue to collect and input data where capacity has allowed them to do so. In other cases, the scheduled dates for undertaking the audits have been revised and we are still awaiting confirmation of some of the new schedules.

In the past 12 months, more clinical teams have been expressing their concerns about a lack of capacity to engage fully with the national audits, consequently in 2020/21, the participation rate was 96%.

Finally, the Covid-19 did afford the opportunity to undertake work not originally scheduled into last year's works programme, during 2020 a collaborative project was undertaken with Digestives Diseases to pull data from multiple data sets into one scorecard for monthly review at their governance meeting. A similar piece of work applying the same methodology has also been applied to tracking clinical outcomes for patients with diabetes. Both projects will be evaluated in 2021 with a view to seeing whether there is merit in expanding this initiative.

2.2 Statements of Assurance from the Board

All NHS trusts are required in accordance with the statutory regulations to provide prescribed information in their Quality Account. This enables the Trust to inform the reader about the quality of their care and services during 2020/21 according to the national requirements. The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2012 / 2017.

Relevant Health Services and Income

During 2020/21 Brighton and Sussex University Hospitals NHS Trust provided a wide spectrum of acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, NHS England and other commissioning organisations to the value of "data not yet available". Service delivery was underpinned by the regular monitoring of metrics reflecting patient safety, clinical effectiveness and patient experience.

Participation in clinical audits and confidential enquiries

During 2020/21 49 national clinical audits and 1 national confidential enquiry covered relevant health services that Brighton & Sussex University Hospitals NHS Trust provides.

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

The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals NHS Trust was eligible to participate in during 2020/21 are as follows:

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T The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals NHS Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry**.**

National clinical audits	Eligible	2020/21 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Yes	Ongoing
BAUS Urology Audit – Cytoreductive Radical Nephrectomy	Yes	Yes	100%
BAUS Urology Audit – Nephrectomy	Yes	Yes	100%
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes	Yes	100%
British Spine Registry	Yes	Yes	Ongoing
Case Mix Programme (CMP)	Yes	Yes	100%
Elective Surgery - National PROMs Programme: Hip & Knee Replacement	Yes	Yes	96.7%
Emergency Medicine: Fractured Neck of Femur	Yes	Yes	100%
Emergency Medicine: Infection Control	Yes	Yes	100%
Emergency Medicine: Pain in Children	Yes	Yes	100%
National Audit of Inpatient Falls	Yes	Yes	100%
National Hip Fracture Database	Yes	Yes	Approx. 99%
Inflammatory Bowel Disease (IBD) Registry	Yes	Yes	Ongoing
Major Trauma Audit	Yes	Yes	Ongoing
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	100%
National Adult Asthma Audit	Yes	Yes	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Yes	Yes	Ongoing
National Children and Young People Asthma Audit	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	100%
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Ongoing
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy)	Yes	No	Insufficient capacity
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%

National clinical audits	Eligible	2020/21 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
National Cardiac Audit Programme (NCAP): Adult Cardiac Surgery	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): Cardiac Rhythm Management (CRM)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): CHD	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): Coronary Angioplasty (PCI)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): Heart Failure	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): MINAP	Yes	Yes	100%
National Diabetes Audit – Adults	Yes	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Yes	85.2%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Yes	32%
National Gastro-intestinal Cancer Programme: Oesophago-Gastric Cancer Audit	Yes	Yes	75-84%
National Joint Registry (NJR)	Yes	Yes	Approx. 98%
National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
National Ophthalmology Audit Database	Yes	Yes	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Vascular Registry	Yes	Yes	Approx 95%
Neurosurgical National Audit Programme	Yes	Yes	100%

National clinical audits	Eligible	2020/21 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA	Yes	No	Insufficient capacity
Surgical Site Infection Surveillance Service	Yes	Yes	100%
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
UK Renal Registry	Yes	Yes	Ongoing

National confidential enquiries	Eligible	Participated	Percentage submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	100%

The reports of 31 national clinical audits were reviewed by the provider in 2020/21 and Brighton & Sussex University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Title	Action taken or planned
National Audit of Inpatient Falls	Nurse falls risk assessments are undertaken daily on at risk patients using a screening tool. However, physio and OT walking assessments are not routinely offered 7 days a week. We will implement a multi-factorial risk assessment (MFRA) to reduce the likelihood of inaccurate falls risk assessment. We will also review the Trust's falls policy, making changes to reflect and incorporate guidelines around MRFA.
National Hip Fracture Database	We will take steps to ensure as many patients as possible are managed on the dedicated Orthopaedic ward (Twineham). This will facilitate prompt assessment (one day post-surgery) by Physiotherapists. Patient First Improvement System and Safety Huddle focus areas to include pressure damage identification and prevention, completion of Malnutrition Universal Screening Tool scores and dietetics referral.
National Oesophago-Gastric Cancer Audit	There is currently no endotherapy service within the Trust. Patients are referred out to another trust which is causing significant delays in their pathways. A new Oesophago-Gastric Consultant will be joining the team in July, already trained in providing this service but the appropriate infrastructure needs to be put into place. We are therefore writing a business case to build this service within the trust.

Title	Action taken or planned
National Cardiac Audit Programme (NCAP): Coronary Angioplasty (PCI)	In the last report, 68% of our STEMI cases had a call to balloon time of less than 150 minutes. This is below the recommended standard of 75% but is consistent with the national average of 69%. Most of the delays would be due to pre-hospital care/ambulance transfers. We intend to look at these specific cases in more detail in order to determine where there is room for improvement.
National Cardiac Audit Programme (NCAP): MINAP	We have timely cardiology review and decision making taking place on both hospital sites within the trust. RSCH Emergency Department NSTEMI admissions are admitted straight to a cardiac bed. PRH admissions are referred to cardiology for consultation and then transferred to RSCH if required. Patients for cardiac rehabilitation are automatically identified from ward handover sheets by the cardiac rehabilitation team.
National Audit of Cardiac Rehabilitation (NACR)	The RSCH site achieved national certification this year. However the PRH site did not, due to delays for assessments with the physiotherapist. To achieve more timely assessment, an increase in physiotherapy hours are required, and the service will therefore explore whether there are avenues available to fund the additional hours that would be required.
National Diabetes Audit – Adults	Although Diabetes-Harms cases are discussed, there are no full root-cause analyses performed on these incidents. We therefore wish to establish a trust-level Diabetes Safety Board, which could provide support to undertake root-cause analysis of diabetes-Harms. We have a Diabetes peri-operative pathway that is used in the Trust and we hold peri-operative diabetes meetings to try to improve the management of diabetes peri-operatively. A business case is being submitted to employ a peri-operative DiSN to improve the adherence to the pathway. We are also developing a diabetes scorecard to bring together numerous strands of data and information that will allow the team to monitor performance and identify issues that would benefit from directed quality improvement projects.
National Emergency Laparotomy Audit (NELA)	A recurring NELA slot is timetabled at anaesthetic and general surgical Quality Safety & Patient Experience (QPE) meetings. Joint QSPE meetings with general surgeons and 'generalist' anaesthetists would allow further discussion and will be put in place. A working group is to be convened to discuss methods of input for the wider MDT, to include geriatricians, radiologists, emergency department. A quality improvement project is underway to redesign/revise the emergency laparotomy pathway and emergency department prompt cards.
National Vascular Registry	Fewer operations than the national average were carried out in the presence of Consultants. However, this is due to a well-trained registrar cadre in vascular surgery who have become highly competent in these procedures. The Consultants at BSUH have previously led the development and delivery of a training course on amputations at the Royal College of surgeons and have trained the registrars well. This is confirmed by the excellent outcomes seen.

Title	Action taken or planned
National Paediatric Diabetes Audit (NPDA)	We discuss our Patient Recorded Experience Measures results in our MDT business meetings and take on board family comments and the wishes of family and young people in improving the service as per their needs. We recently sought input from our families on how they viewed our way of incentivising pump therapy, and we then revisited our practice on this basis making it more young-person-friendly. In addition, our families expressed a wish for a more comprehensive transition process and we are therefore now planning to organise opportunities to meet with our young people and families to discuss their wishes and improve our transition service. This is being implemented with the addition of a new consultant and more Clinical Nurse Specialist (CNS) staff to re-shape our transition service. Training for school staff is developed, organised and delivered by our CNS staff. During the pandemic this has been happening virtually via Zoom.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Guidelines, expressing and breast feeding support and facilities are already in place to maximise breast feeding. A business case has been submitted and is under review for improved nursing staffing levels. Regarding reducing the proportion of babies affected by bronchopulmonary dysplasia, a new guideline was introduced in 2020, monitoring is taking place using Vermont Oxford Neonatal Database. We have already met the target for incidence of necrotising enterocolitis, (NEC) however we wish to continue to improve if possible. Hence a new NEC prevention guideline is in preparation.
British Thoracic Society National Audit of Non-Invasive Ventilation (NIV)	Significant improvements have been achieved since NIV teaching/competency has been delivered by and appointed NIV critical care nurse. Teaching and a proforma were implemented in 2020 so we will look to the next audit cycle to see whether there are improvements in domains for uptitrating NIV/ABG monitoring. Critical care outreach 24/7 has significantly improved rate of patients on acute NIV being assessed within 2 hours of initiation which should improve outcomes/mortality. We have plans for NIV inreach to allow subspeciality NIV input for all patients on NIV.

Title	Action taken or planned
National Audit of Care at the End of Life (NACEL)	BSUH has developed an 'Individualised Care Plan for a Dying Person' with associated training. This can be found on the BSUH 'microguide'. It is monitored via the BSUH End Of Life Care Steering Group (EOLCSG). The EOLCSG will work with Medical Examiners, Chaplaincy and Bereavement Office and develop a business case to support Bereavement Services at BSUH. This is to enable the service to provide the best support to people important to the dying person through their bereavement, with the aim of better meeting people's needs and preferences. To support staff in gaining competence and confidence in communicating effectively and sensitively with the dying person and people important to them, BSUH uses nationally recognised Sage & Thyme Communication Tool in its communication workshop. Clinical Fellows will work with BSMS post graduate centre on the Second Conversation initiative.

The reports of 48 local clinical audits were reviewed by the provider in 2020/21 and Brighton & Sussex University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Speciality	Project Title	Actions to improve the quality of care
Acute Floor	Oxygen therapy for acutely ill medical patients	• Develop trust guidelines for: (i) when to start oxygen therapy and (ii) when to attempt oxygen weaning. • Introduce training/cheat sheets to nurses summarising the above guidelines and prompting the need for oxygen prescribing by a Clinician. • Consider changing drug chart oxygen prescription pre-set targets from 94-98% to 94-96%.
Acute Medicine	Non-Invasive Ventilation (NIV) – A quality improvement project	• Education programme to up skill staff on the acute floor on when to do an arterial blood gas and to educate them around the ineffective use of NIV in the treatment for pneumonia, and the need to consider ITU or palliation And/or • Need for an early respiratory review of patients starting NIV on the acute floor and to discuss every patient starting NIV with a senior respiratory Consultant.
Acute Medicine	An initiative to improve National Early Warning Score 2 (NEWS2) documentation for patients presenting to acute medicine to enhance quality, safety and efficiency of care.	To ascertain if a new type of visual prompt (Weebles) can improve NEWS2 documentation: • There was a significant improvement on the reporting of NEWS & temperature at 1 week, but not at 3 months. • Weebles proved to be an inexpensive, fun and effective visual prompt for clinicians in the short term • Future work needs to focus on long-term retention and comparison between different visual prompts, such as Weebles versus posters.

Speciality	Project Title	Actions to improve the quality of care
Acute Medicine	Management of non-surgically acquired cellulitis	• Skin swabs frequently yield negative results, particularly if the skin is intact, and should be reserved for cases where the skin is broken, or there is a history of penetrating injury, or exposure to water-borne organisms or travel outside the UK. • We have designed and implemented clinical prompt cards to address key aspects of cellulitis management where improvement is most needed; specifically reducing unnecessary investigation and optimising antibiotic stewardship. • The audit cycle will be repeated after 2 months to assess the impact on patient management.
Breast Surgery	Breast symptom referral audit	The introduction of a local breast symptom referral proforma: • Enhanced service efficiency and service optimisation. • Enhanced collaboration and networking with Primary Care, Cancer Alliance, Clinical Commissioning and in-service colleagues. • Saved costs in both primary and secondary care • Improved the patient journey, as a consequence enhanced management of patients with low risk symptoms.
Cardiology	Improving interpretation of coronary angiography: a pilot quality improvement project	The introduction of a newly written digital guide has demonstrated increased ability in interpreting coronary angiogram in the small number of candidates recruited into this pilot study. The basic digital guide was presented to the local trust medical education committee who endorsed incorporating the guide into an e-learning module for wider dissemination.
Cardiothoracic Surgery	Concomitant surgical atrial fibrillation (AF) ablation follow-up against best-practice standards at a tertiary cardiac surgery centre in Brighton.	A nurse-led arrhythmia clinic can prevent AF-related hospital admissions by ensuring cost-effective review, optimal anticoagulation and rate/rhythm control.
Cardiothoracic Surgery	Evaluation of the management of sternal wound infections in cardiothoracic surgery patients	Based on the findings of this audit and the evidence-based recommendations found in the international literature we formed a list of 17 suggestions for the management of sternal wound infection in cardiothoracic surgery patients.
Diabetes/Endocrinology	Diabetes & frailty	Poster developed with supplementary education sessions.

Speciality	Project Title	Actions to improve the quality of care
Diabetes/Endocrinology	Audit of patient experience & outcomes from hydrocortisone patient education sessions.	• Continue sessions. • Encourage patients to attend with partner/other. • Remind patients to inform nurse specialist if admitted with adrenal crisis.
Diabetes/Endocrinology	Patient preferences for telephone or face to face follow up appointments in the metabolic bone clinic	• Supports telephone follow up for this clinic. • Continue current follow up arrangements.
Diabetes/Endocrinology	Tolvaptan use at PRH for syndrome of inappropriate antidiuretic hormone secretion (SIADH)	• Continue limited use under Endocrine Consultant supervision. • Await further outcome data from clinical trials and review local use accordingly.
Ear Nose & Throat (ENT)	Audit looking at consent in functional endoscopic sinus and septal surgery.	• Teaching session on consent factors for each surgery at departmental teaching. • Summary of findings emailed to ENT team with bullet points on consent points that need to be included for each surgery • Clarify if any specific reason some factors in consent were included/ not included • Plan for re-audit and closing the audit cycle once elective surgery recommences with same ENT department.
Elderly Medicine	Malnutrition screening in elderly care wards	• Results discussed with elderly care consultants • Relayed findings to Dietetics department (consistent with previous audit in 2018 of 42%). • Presentation to elderly care junior doctors planned • Elderly care consultant to relay findings to safety, quality and performance meeting. • Development of a flow chart and/ or updated screening questions for use in the acute admissions unit (AAU) to ensure at risk patients have prompt referral and oral nutritional support can be started while awaiting assessment by a dietician.
General Surgery	Timing of surgery following Covid-19 infection - Digestive Diseases	• Recommend a 7 week-delay between COVID and surgery

Speciality	Project Title	Actions to improve the quality of care
General Surgery	Performance of an Emergency Ambulatory Care Unit (EACU) for surgical patients (and re-audit).	• Process-driven EACU can be the most effective way • Missed opportunities and waste categories account for almost one-fourth of EACU referrals. Consultant delivered acute surgical care may eventually help to improve both these areas. • A re-audit found; more senior review than before; more number of same day discharges (72% vs 60%); more complete discharge letters (94% vs 82%). Process was still the major provider effort category though marginally lower (52% vs 60%).
General Surgery	Management of pancreatitis	• Patient information leaflets need updating • Pancreatitis pathway established. • Scoring to identify high risk patients and early liaison with ITU. • Re-audit in 3 months.
General Surgery	Clerking & prescribing audit	• Cascading the results of this audit to the doctors, pharmacists, and nurses on L9a to raise awareness of the issues identified through posters. • Pharmacists and doctors informing each other when clerking and prescribing of a patient is required, respectively. • The findings of this audit and a review of good prescribing guidelines to be set-up and delivered as an online teaching session. • A re-audit to be performed in 6-8 weeks' time to check the improvement of these factors.

Speciality	Project Title	Actions to improve the quality of care
General Surgery	Ward round documentation: Are we adhering to Royal College of Surgeons (RCS) good surgical practice?	Created an Access database proforma that allows all patient details, observations and recent investigations to be automatically updated in a single A4 sheet. Having a single sheet with all the data present meant more time could be spent with the patient forming clearer plans which also made it easier for continuity of care. Doctors were updated on how to use the database and the need to print them off before the ward round. Ward notes were then re-audited against the same RCS Good Surgical Practice Criteria. Overall, a significant improvement in documentation and criteria met. All documentation was legible with the date, time and patient details stated. Plans to: • Continue to develop the proforma and database to make it as easy to use as possible. For those struggling to use it, we have offered further training. • Plan is to re-audit this again and continue to develop the proforma. In some hospitals this electronic system is integrated already with the observations and bloods and this could be a potential area to look at further.
General Surgery	Management of Acute Kidney Injury (AKI) in a surgical unit	The incidence of AKI in acute surgical patients is common (approximately 7% of admissions to this department). Most of these admissions had pre-existing medical or surgical co-morbidities. Guidance on intravenous (IV) fluids and holding medications was adhered to, which may have spared most patients from operative morbidity. However, nearly all patients received contrast for a CT scan, which may have been unavoidable in diagnosis and surgical planning. It is important to rationalise the use of contrast in such patients. Accepted as an E-poster at ASGBI Centenary meeting 2020
Intensive Care Unit	Antiretroviral drug Prescribing in the Intensive Care Unit (ICU): An audit and quality improvement project	• Addition of learning resources on critical care intranet site • Teaching session (online/in person) for new cohort of clinicians joining in August • Re-audit and re-assessment
Intensive Care Unit	Compliance of the Intensive Care Unit (ICU) with the NHS Healthy Working Environment Framework	• BSUH should invest in providing nutritious food across all areas 24/7, and make changes to provide staff rest areas in line with new social distancing guidance.

Speciality	Project Title	Actions to improve the quality of care
Intensive Care Unit	Covid blood tests audit	PCT is probably the most helpful parameter when assessing inflammatory state in Covid-19, the recommendation is therefore to limit the use of other tests that may be less specific.
Intensive Care Unit	Rib fracture management audit in Critical Care	Highlight need to engage with rib fracture pathway at Trauma Governance.
Intensive Care Unit	Secondary/tertiary survey audit	Completion of secondary/tertiary survey in polytrauma is poor: • Quality improvement project commenced • Emergency Department to also audit • Orthopaedic team made aware
Intensive Care Unit	Psychological morbidity in ICU admissions	• Increase education in relation to risk factors • Bid for an ICU psychologist role
Intensive Care Unit	Burnout in ICU	We learnt that there are significant levels of burnout in ICU, especially during the Covid-19 pandemic. We have implemented simple improvements as suggested by the participants and scheduled a re-audit. Accepted to present poster at Bristol Patient Safety Conference national online conference June 2021
Neuro Medicine	Audit of prescribing and treatment response of Erenumab in chronic migraine	To continue use, although this has been superseded by NICE guidance in 2021. Erenumab is now available on the NHS together with other CGRP monoclonal antibodies. We will re-audit again towards the end of 2021.
Maxillofacial/Oral Surgery	Post-op documentation of oral and maxillofacial surgery free flap procedures	• Roll out new proforma • Re-audit data after 3 months of use • Emphasize importance of efficient documentation at induction
Paediatric Orthodontics	An audit to assess the re-exposure rates of impacted teeth: are we doing it right?	• Orthodontics to supply more information on position of tooth, desired exposure and chain position in referral letter. Adoption of e-proforma could be considered. • Surgeons to ensure details of both open/closed exposures and position of bracket are included in the operative notes for the staff completing discharge summaries to ensure consistency with operative records. • It's recommended that there is attendance at all joint clinics by both surgical and orthodontic teams to facilitate improved communication and outcomes for patients.

Speciality	Project Title	Actions to improve the quality of care
Paediatric Orthodontics	An audit to assess the number of replacement orthodontic retainers made	• Review retention regime and consider retainer consent policy at de-bond. • To consider reducing full time wear from 3 months to 1 month as most replacements due to wear and tear, thus if patients are wearing the retainers part time for longer, fewer retainer remakes may be required.
Paediatric Orthodontics	Orthodontic service evaluation	• To inform patients during the consent process that the average treatment duration is 2 1/2 years within the department. • Re-audit annually and ensure patients undergoing interceptive orthodontic treatment with removable appliances are included.
Paediatric Orthodontics	Quality of orthodontic photographs: re-audit	• An improvement in the quality of photographs was seen since the teaching session carried out post 1st audit. • Further improvements are still required on intra oral buccal views. • Re-audit 12/12 and include a section on whether the photos are clinically acceptable as well as the grade.
Paediatric Orthodontics	A re- audit to assess orthodontic health records	• Clinicians to ensure health questionnaire is completed annually • Amendments in the notes to be signed and dated. • Details of the clinician and nurse to be added to the clinical notes. • In line with trust policy to re-audit annually.
Paediatric Orthodontics	Consent for treatment in an Orthodontic department	• Training undertaken on the completion of consent forms • To ensure clinicians complete all sections of the form and document consent and discussion in the case notes. • Discussion on deciding a reasonable time frame for confirmation of consent. • Re-audit in 12 months' time
Paediatric Orthodontics	Evaluating clinical and patient-centred outcomes in an Orthodontic Department	• Review de-bond form layout • Clinicians to fully complete form • Improve communication re: clinics running late • Improve communication re: treatment duration • Analyse data on a yearly basis • Next audit: August 2021 for July 2020 – June 2021

Speciality	Project Title	Actions to improve the quality of care
Paediatric Orthodontics	Health Records in an Orthodontic Department: a three cycle re-audit	• Clinicians to ensure alterations are acknowledged as per trust guidelines. • Study model box numbers are written on the front cover; all entries are legible, written in black ink and correctly signed off with designation and printed name; to complete the orthodontic summary sheet and ensure the medical history is updated at each visit and the health questionnaire updated annually. • The use of existing stamps with the clinician's name and designation should be utilised regularly. • Administrative staff to ensure case notes are in a good condition with an orthodontics sticker; only appropriate information is present on the front cover; all case notes have a patient identification sheet with emergency contact details present. • As per the trusts health record policy, a re-audit should take place within 12 months of implementing the action plan.
Paediatric Surgery	Paediatric emergency airway and foreign body Ear Nose & Throat (ENT) equipment audit	• The new guidelines will be addressed and presented to the ENT department as there was not an awareness that these had changed and what the expectations were. • Theatre equipment lead will get in contact with manufacturers to identify how to order the specific new sizes of bronchoscopes. • Theatre equipment lead will clarify which model numbers of paediatric tracheostomies we have currently present. • We also highlighted that there was currently only one ENT equipment lead who knew about ordering the equipment and about the ENT emergency airway equipment. It was suggested that there should be a refresher for the rest of the ENT theatre team on how to order the emergency equipment should the need arise.
Renal Medicine	Renal procedures audit	• Removal of duplicate entries of vascular access from electronic patient records. • CVC insertion care bundle to be replaced by new one page proforma. • To make it policy for documented one week reviews when re-prescribing and discontinued if no growth.

Speciality	Project Title	Actions to improve the quality of care
Renal Medicine	Acute kidney injury audit	• There is an ongoing review of late presenters to the service (known <90 days before starting dialysis) to identify any themes as to how to identify these patients sooner. • Support to deliver NephWork submission streamline collection of outcomes data • Address missing data
Renal Surgery	Renal transplant audit	• Development of an annual review proforma/checklist. • Explore availability of algorithm for predicting eGFR decline and if this can be incorporated into reporting.
Thoracic/Respiratory Medicine	British Thoracic Society (BTS) local bronchiectasis audit	• Review and redesign of bronchiectasis data capture, specifically around capturing which patients have received a self-management plan and which have been referred to pulmonary rehabilitation. • Education of patients of the importance of providing regular sputum samples prior to commencing antibiotics. This will allow a targeted approach to treatment and early recognition of chronic infections.
Trauma & Orthopaedics	Open lower limb fractures: Are we following the British Orthopaedic Association Standards for Trauma and Orthopaedics (BOASTs) guidelines on photography and soft tissue coverage? Retrospective closed-loop audit	Findings from 1st audit presented in poster format to the orthopaedics governance meeting. Re-audited showed an improvement in the pre-debridement photographs in comparison to the first cycle. Also, the post debridement photograph increased dramatically in comparison to the first cycle.
Trauma & Orthopaedics	Ankle fractures: Are we offering patients adequate rehabilitation advice after open reduction internal fixation surgery? Retrospective closed-loop audit	A new leaflet was introduced in March 2020 as a result of the 1st audit cycle. These changes were introduced during the COVID-19 period when patients had virtual appointments. The 2nd cycle showed that most indicators were positively improved, indicating higher adherence to the guidelines. The total percentile of adherence to guidelines improved in the second cycle.
Trauma & Orthopaedics	Thromboprophylaxis and Venous thromboembolism (VTE) rates following accelerated functional rehabilitation for Achilles tendon rupture	• Discussion with haematology department regarding the optimal VTE prophylaxis protocol. • Addition of VTE risk assessment on virtual fracture clinic proforma.

Speciality	Project Title	Actions to improve the quality of care
Trauma & Orthopaedics	Re-audit of tip-apex distance for fixation of extracapular neck of femur fracture.	• A couple of patient's intraoperative fluoroscopy images where not loaded onto the local imaging review system. This should be highlighted to the radiology department • Surgeons must be made aware to double check the data entered into the template on Bluespier prior to completing the operation notes.
Trauma & Orthopaedics	Fracture related infections - Communication with patients and primary care	• To embed proper communication via discharge paper work.
Vascular Surgery	Pain management in critical limb ischaemia: a clinical audit (and re-audit)	• Analgesia education sessions for incoming Senior House Officers (SHOs). • Inclusion of the analgesia dosing table in the vascular clerking proforma. • A simplified version of the analgesia table being formatted into a poster for the vascular doctor's office. • Re-audit: Recommendation to continue the above interventions.
Vascular Surgery	Port-a-cath insertion audit	• Post-operative booklet developed.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Brighton and Sussex University Hospitals NHS Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 2802.

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

Due to the Covid-19 pandemic the operation of the CQUIN (both CCG and specialised) framework was suspended for the whole of 2020/21; providers did not need to implement CQUIN requirements, carry out CQUIN audits nor submit CQUIN performance data. For Trusts, an allowance for CQUIN will continue to be built into nationally-set block payments.

Statements from the Care Quality Commissioner (CQC)

Brighton and Sussex University Hospitals NHS Trust was required to register with the Care Quality Commission and its current registration status came to an end on the 31st March following the acquisition by Western Sussex Hospitals Foundation Trust

The Care Quality Commission has not taken enforcement action against Brighton and Sussex University Hospitals NHS Trust during 2020/21.

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

NHS Number and General Medical Practice Code Validity

Brighton and Sussex University Hospitals NHS Trust submitted records during 2020/21 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (April 2020 – February 2021):

Which included the patient's valid NHS number was:

99.6% for admitted patient care:

99.9% for outpatient care and

98.2% for accident and emergency care

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

100% for admitted patient care;

100% for outpatient care; and

99.8% for accident and emergency care

Data Security and Protection Toolkit Attainment Levels

Each year the Trust completes and submits the Data Security and Protection Toolkit (DSPT) to demonstrate its compliance against the National Data Guardian's National Data Security Standards. As organisations continue to focus on the operational priorities associated with the outbreak of COVID-19, NHS Digital (NHSD) agreed that the publication date for the 2020-21 submission would be 30th June 2021. Given that the Trust merged with Western Sussex Hospitals NHS Foundation Trust to form the University Hospitals Sussex NHS Foundation Trust from 1st April 2021 the decision was taken to make the BSUH toolkit submission before the merger. A compliant DSPT submission was therefore made on 30th March 2021.

Clinical Coding Error Rate

Brighton & Sussex University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2020-21 by the Audit Commission.

Data Quality

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

- Continue to log DQ related incidents on DATIX and encourage all departments to log these incidents. Monitor these cases and provide training and support to areas that would benefit from this most.
- Demographic Batch Service (DBS) processes to run as normal twice a day. Introduce a new monthly DBS tracing of 'Dates of Death' and 'Name Aliases of new-borns' for the entire PAS Index from the NHS Spine (~1.5 million records).
- Continue to actively promote and push for all staff to utilize the available resources (DQ Information Pack) as well as the two e-modules (Patient Identification and Data Quality Awareness).
- Continue working with data owners and system managers to address the Data Quality Improvement Strategy actions.

Learning from Deaths

Deaths in 2020/21

During 2020/21 1644 of Brighton & Sussex University Hospitals NHS Trust patients died (of which 16 were neonatal deaths/stillbirths, 1 were people with learning disabilities and 3 had a severe mental illness). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 375 in the first quarter (of which 3 were neonatal deaths/stillbirths, 0 were people with learning disabilities and 0 had a severe mental illness).
- 288 in the second quarter (of which 6 were neonatal deaths/stillbirths, 0 were people with learning disabilities and 0 had a severe mental illness).
- 415 in the third quarter (of which 2 were neonatal deaths/stillbirths, 1 were people with learning disabilities and 1 had a severe mental illness).
- 566 in the fourth quarter (of which 5 were neonatal deaths/stillbirths, 0 were people with learning disabilities and 2 had a severe mental illness).

Mortality Reviews

By 31 March 2021, 21 case record reviews and 142 investigations have been carried out in relation to 162 of the deaths.

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

- 51 in the first quarter;
- 11 in the second quarter;
- 50 in the third quarter;
- 51 in the fourth quarter.

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

142 representing 8.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This reflects the 139 patients diagnosed with nosocomial COVID-19 infection and who had COVID-19 recorded on either part 1 or part 2 of their death certificate in this timeframe.

In relation to each quarter, this consisted of:

- 50 representing 13% for the first quarter;
- 6 representing 2% for the second quarter;
- 42 representing 10% for the third quarter;
- 44 representing 8% for the fourth quarter.

These numbers have been estimated using the mortality review and serious incident investigation framework.

Investigations into 34 (31 relating to nosocomial COVID-19 infection) deaths in the reporting period remain ongoing at the time of writing.

Learning from case record reviews and investigations

Missed acute coronary syndrome in the Emergency Department (ED) – unexpected deaths following patient discharge from the ED. Identified care issues included misinterpretation of the chest pain pathway, a failure to review and/or repeat critical blood test results and the impact of reduced senior medical staffing levels.

Action following our learning
Human Factors refresher training and education has been rolled out in the ED for Foundation and senior trainee (Registrar) staff.

The cases have been presented at junior doctors' induction to illustrate the wide potential diagnoses for similar presentations and the importance of following up on all investigation results. One case study is now included in the junior doctor induction handbook.

The Pathology and the ED teams are working together for the introduction of an automated system to alert clinicians when results are pending to ensure that all blood requested tests will automatically be visible on ICE once received by the laboratory.

Work remains ongoing in addressing ED middle grade and above doctor shortages.

An Advanced Care Practitioner programme is under development.

The impact of our actions
The action plan was commended by the Clinical Commissioning Group (CCG) and will be monitored via the Quality Review Meeting to provide assurance on the medical staffing levels in the ED.

Mortality reviews relating to deaths during the previous reporting period
59 case record reviews and 2 investigations completed after 31 March 2020 which related to deaths which took place before the start of the reporting period

Patient deaths judged to be more likely than not to have been due to problems in care during the previous reporting period
0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

Revised estimate of deaths judged to be more likely than not to have been due to problems in care during the previous reporting period
0 representing 0% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Implementing the Priority Clinical Standards for 7 Day Services

This programme of work was not carried out by NHS England during 2020/21. From 2019 the reporting of 7 Day Services was moved to a Board Assurance framework with Acute Trusts being required to use a self-assessment template to report on their performance twice yearly. However, due to the COVID-19 pandemic Trusts were instructed to suspend the self-cert statement.

Staff Who Speak Out

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

The trust's present Freedom to Speak Up Guardian has been in post since November 2020 and works with individuals, teams and groups to promote speaking up including, for example, attending events such as: staff inductions; junior doctor inductions; staff training and development events; local staff conferences and diversity and inclusion events. In addition to this the Freedom to Speak Up Guardian works collaboratively with staff from Patient Safety and Human Resources, and reports twice yearly to the Trust Board.

During 2020, the Freedom to Speak Up Guardian's annual (calendar year) report showed an overall increase of over 50% in the number of staff speaking up directly to the Freedom to Speak Up Guardian. This increase mirrored the experience of many other Guardians throughout the COVID-19 pandemic as did the large increase in staff safety matters related to the pandemic including about: personal protective equipment (PPE) issues; social distancing and COVID working arrangements.

The 2020 staff survey has shown a 0.5% increase in staff saying they feel secure raising a concern about unsafe clinical practice at 70.6%; 1.2% below the National Average. The Trust continues to exceed the national average with its 1.7% year on year increase in response to "my organisation treats staff who are involved in an error, near miss or incident fairly." Our safety culture score of 6.5 is 0.3 behind the National Average score of 6.8.

BSUH promoted a culture which encourages staff to speak up. As part of embedding speaking up as 'business as usual' throughout the trust, for most situations, staff are encouraged to approach their line manager/supervisor/team leader. Because of the importance manager's play at this stage and the value of good communication, training has been put in place to support these key staff members to have quality conversations with staff with further training currently being embedded within the trust. Staff can also access support from a number of parties including: directly from the Freedom to Speak Up Guardian; Connections team; HELP a psychotherapy service; staff networks; and the Diversity and Inclusion Team.

Rota Gaps and Plans for Improvement

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

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

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

The 2020/21 Quarter 2 (July to September) report highlighted that 69 exception reports had been submitted, compared to 350 in the same period in 2019.

The 2020/21 Quarter 3 (October to December) report highlighted that 92 exception reports had been submitted compared to 268 in the same period in 2019. Which is remarkable given the pandemic and is testament to a number of positive factors across the trust.

It was noted that a common feature within the 2020 quarterly reports was the provision of hot food available to the Junior Doctors at night and the trust is working to support this, largely through the 3Ts programme.

In common with previous quarterly reports, a number of exceptions were raised due to late finishes. Whilst the rostering aims to reduce the need for late stays by providing someone to handover to, it would seem that some late finishes are unavoidable. The hours worked in excess of a maximum 13 hour shift are paid at 1.5 x standard rate.

Junior doctors working in medical specialties and in general surgery are now on Healthrota. Since the introduction of Healthrota in December 2019 the numbers of exception reports have been reduced. A causal relationship is difficult to prove, however, it seems likely that the new rostering system which ensures more consistent staffing is at least partly responsible.

The other factor throughout 2020 has been the way the Covid19 pandemic has affected rostering and attitudes towards exception reporting. The reduction in exception reporting appears to be a regional (if not national) phenomenon.

2.3 Reporting Against Core Indicators

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

The majority of core indicators are reported by financial year, e.g. from 1st April 2020 to 31st March 2021, however some indicators report on a calendar year or partial year basis. Where indicators are report on a non-financial year time period this is stated in the data table. It is important to note that some national data sets report in significant arrears and therefore not all data presented are available to the end of the current reporting period (31st March 2021).

Summary Hospital-Level Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who died following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI gives an indication for each non-specialist acute NHS trust in England on whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

Indicator Domain	Summary Hospital-level Mortality Indicator Preventing people from dying prematurely				
BSUH 2020	National average 2020	Best performing Trust 2020	Worst performing Trust 2020	BSUH 2019	BSUH 2018
105.77 ***As expected***	100.00 **As expected**	69.51 ***Lower than expected***	118.69 ***Higher than expected***	97.68 ***As expected***	97.94 ***As expected***
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data				

Table based on latest available data (December 2019 - November 2020)

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

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

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

Indicator **Domain**	Percentage of patient deaths with palliative care coded at either diagnosis or specialty level Preventing people from dying prematurely				
BSUH 2020	National average 2020	Highest performing Trust 2020	Lowest performing Trust 2020	BSUH 2019	BSUH 2018
2.3%	1.9%	3.8%	0.5%	2.4%	1.8%
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

Table based on latest available data (September 2019 - August 2020)

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

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services by regularly monitoring mortality data at the Trust Mortality Review Group.

Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves for the following procedures:

Hip replacement surgery;

Knee replacement surgery.

Indicator **Domain**	Patient Reported Outcome Measures EQ 5D Index (casemix adjusted health gain) Helping people to recover from episodes of ill health or following injury					
Type of Surgery	BSUH 2019/20	National average 2019/20	Best performing Trust 2019/20	Worst performing Trust 2019/20	BSUH 2018/19	BSUH 2017/18
Hip replacement	0.437	0.453	0.524	0.411	0.464	0.439
Knee replacement	0.314	0.334	0.359	0.264	0.314	0.317
Data Source	https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms					

The most recently published adjusted health gain figures available are finalised data covering the period 2019/20.

Above are the adjusted average health gain figures for the EQ5D outcome measures.

Latest available data (2019/20, finalised data published Feb 2021)

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

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services by continuing to carry out dedicated washing and dressing assessments in the Orthopaedic Treatment Centre and providing additional patient education in this area.

Patients readmitted to a hospital

The percentage of patients aged:

- 0 to 17; and
- 18 or over

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

Indicator **Domain**	Crude Readmission Rate for patients readmitted to a hospital within 30 days of being discharged Helping people to recover from episodes of ill health or following injury					
Age Group	BSUH 2020	National average 2020	Best performing Trust 2020	Worst performing Trust 2020	BSUH 2019	BSUH 2018
Patients aged 0 to 17 years	9.70%	12.30%	0.00%	44.10%	8.28%	8.90%
Patients aged >18 years	13.49%	14.63%	0.00%	27.23%	8.58%	8.56%
Data Source	Activity and Readmission Data produced using Healthcare Evaluation Database					

Table based on latest available data (January 2020 – December 2020)

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

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

Responsiveness to the personal needs of patients

The Trusts responsiveness to the personal needs of its patients during the reporting period is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Indicator Domain	Responsiveness to the personal needs of patients Ensuring people have a positive experience of care				
BSUH 2020/21	National average 2020/21	Best performing Trust 2020/21	Worst performing Trust 2020/21	BSUH 2019/20	BSUH 2018/19
68.2%	67.1%	84.2%	59.5%	67.6%	67.8%
Data Source	NHS Digital https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs				

Table based on latest available data (February 2021)

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

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

Staff who would recommend the trust to their family or friends

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

Indicator Domain	Percentage of staff who would recommend the Trust as a provider of care to their family or friends Ensuring people have a positive experience of care				
BSUH 2020	National average 2020	Best performing Trust 2020	Worst performing Trust 2020	BSUH 2019	BSUH 2018
68.4%	73.4%	92.0%	50.0%	66.1%	67.7%
Data Source	NHS NHS Staff Survey Results – NHS Staff Survey Results				

Table based on latest available data (2020)

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

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to focus on staff engagement as part of the Leadership, Culture & Workforce programme with the overall aim of improving staff engagement across the Trust. We have a True North objective to be in the top 20% of NHS employers in future staff survey results.

Patients who would recommend the trust to their family or friends

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

Indicator **Domain**	Percentage of patients who would recommend the Trust as a provider of care to their family or friends Ensuring people have a positive experience of care				
BSUH 2020/21	National average 2020/21	Best performing Trust 2020/21	Worst performing Trust 2020/21	BSUH 2019/20	BSUH 2018/19
93.1%	Data not yet available	Data not yet available	Data not yet available	93.8%	93.3%
Data Source	NHS England				

Table based on latest available data (December 2020 to March 2021, the FFT test was suspended between April and November)

The Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reason that the data is captured by an external company.

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

Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

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

Indicator **Domain**	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism Treating and caring for people in a safe environment and protecting them from avoidable harm				
BSUH 2020/21	National average 2020/21	Best performing Trust 2020/21	Worst performing Trust 2020/21	BSUH 2019/20	BSUH 2018/19
*	*	*	*	91.2%	92.6%
Data Source	NHS Digital NHS England » Venous thromboembolism (VTE) risk assessment 2019/20				

* The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic

Rate of *C.difficile* infection

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

Indicator Domain	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 Treating and caring for people in a safe environment and protecting them from avoidable harm				
BSUH 2020/21	National average 2020/21	Best performing Trust 2020/21	Worst performing Trust 2020/21	BSUH 2019/20	BSUH 2018/19
16.42	17.08	0.00	76.01	18.52	16.1
Data Source	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure				

Table based on latest available data February 2020 to January 2021

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

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

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

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

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

Indicator Domain	Patient safety incidents and the percentage that resulted in severe harm or death Treating and caring for people in a safe environment and protecting them from avoidable harm					
	BSUH 2019/20	National average 2019/20	Best performing Trust 2019/20	Worst performing Trust 2019/20	BSUH 2018/19	BSUH 2017/18
I	44.51	49.06	106.95	26.90	41.76	38.95
Ii	0.07	0.15	0.55	0.01	0.04	0.07
iii	22	39	183	1	13	20
Iv	0.16	0.31	1.13	0.02	0.10%	0.17%
Data Source	NHS Improvement https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-data/					

Table based on latest available data April 2019 to March 2020

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

The Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by continually encouraging staff to support the development of individual specialist and incident type reporting pages to make it easier for staff to report incidents. As a consequence, despite a significant reduction in the number of incidents reported in the second half of March 2020, the number of incidents reported has risen from 12,196 in 2018-19 to 13,743 in 2019-20.

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

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

3.1 Other Quality Information

The following section contains a listing of the projects planned in 2020-21, as discussed in section 2.1 the majority of initiatives were suspended due to the Covid-19 pandemic.

Patient Safety

Elimination of severe pressure ulcers

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

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

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

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

Targets set for 2020/21	Status	Narrative
Due to the COVID-19 pandemic no objectives were set for 2020/21 for this initiative.	N/A	Whilst no targets were established pressure ulcers were continually monitored and reviewed during 2020/21, and the rate of acquired pressure ulcers was 1.09 per 1000 bed days, exactly the same rate as in 2019-20.

Falls prevention

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

Since 2009-10, the Falls Prevention Programme has reduced the rate of falls in BSUH by 48% and has sustained this improvement over 5 years. To date, it's estimated that the project has prevented

over 5200 inpatient falls. In 2017 NHS Improvement published 'The Incidence and costs of inpatient falls in hospital', this document estimated that the average cost of an inpatient falls was £2600 as a result of potentially prolonged hospital stay, diagnostic and surgical and non-surgical interventions. Based on this estimate the falls project has produced a saving in excess of £13.5m.

Targets set for 2020/21	Status	Narrative
Due to the COVID-19 pandemic no objectives were set for 2020/21 for this initiative.	N/A	Whilst no targets were established falls were continually monitored and reviewed during 2020/21. The programme on falls, which is now in its 10th year, was recognised in a number of national publications during the past year – the British Journal of Nursing, NHE Digital and the Nursing Standard. During 2020-21 the adult inpatients falls rate was 3.71 falls per 1000 bed stay days, which was marginally higher than the previous year's rate of 3.68. The last available national data for falls reported a rate of 6.6 falls per 1000 bed days.

Improving the care of patients with venous thromboembolism

Venous thromboembolism (VTE) is a leading cause of death and disability in the UK. It is a condition in which a blood clot forms, most often in the deep veins of the leg, groin or arm (known as a deep vein thrombosis or DVT) and travels in the circulation, lodging in the lungs (known as a pulmonary embolism or PE). This initiative was designed to undertake a baseline assessment of current performance and improve the governance arrangements for reporting hospital associated VTE.

Targets set for 2020/21	Status	Narrative
Due to the COVID-19 pandemic no objectives were set for 2020/21 for this initiative.	N/A	Whilst no targets were established VTE rates were continually monitored and reviewed during 2020/21. During the past 12 months the VTE team has conducted 198 root cause analysis investigations and identified 8 preventable incidents of VTE's.

Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery

NICE guidance illustrates the importance of offering iron before surgery to patients with iron-deficiency anaemia. This project focuses on the importance of screening and treatment in line with that guidance.

Improved compliance with the guidance would reduce blood transfusion rate for major blood loss surgeries and reduce the occurrence of patient safety risks associated with blood transfusion including fluid overload, infection and incorrect blood transfusions being given.

Overall, it is estimated that consistent uptake of screening to 60% would deliver savings of around £3m associated with units of blood being saved due to lower transfusion rates, reductions in critical care periods, saved bed days and reductions in admission rates.

Targets set for 2020/21	Status	Narrative
Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE Guideline (NG) 24.	N/A	Due to the COVID-19 panademic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

Supporting the anti-microbial resistance agenda by better targeting the usage of Antifungals

This project supports “system-wide improvement, surveillance, infection prevention and control practice, and antimicrobial stewardship” by better targeting the usage of antifungals.

Antifungal spend is in excess of £80 million per year, with inappropriate spend estimated at £11 to £25 million.

In line with World Health Organisation (WHO) estimates on a worldwide build-up of resistance, the costs associated with treating patients who have developed fungal resistance will increase rapidly.

Targets set for 2020/21	Status	Narrative
75%-90% of patients to have been treated by approved anti-fungals as per local guidelines, and to have been reviewed appropriately by an antifungal stewardship team within 7 days.	N/A	Due to the COVID-19 panademic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

Effectiveness

Improving care for the deteriorating patient – Sepsis

Sepsis, a syndrome of physiologic, pathologic, and biochemical abnormalities induced by infection, is a major public health concern, accounting for more than 52,000 deaths in the UK in 2018. Problems in achieving consistent recognition and rapid treatment are thought to contribute to the number of preventable deaths from sepsis every year.

National contract requirements, outlined in the previous CQUIN framework, aimed to embed a systematic approach for prompt identification and appropriate treatment of life-threatening infection.

For 2020/2021 a deteriorating patient CQUIN was planned which would focus on the recording of NEWS2 score, escalation time and response time for critical care admissions. The NEWS2 protocol is evidence based best practice for identifying the signs of deterioration in a patient, alongside clinical judgement. Considerable work has been delivered across the country over the past few years to improve the identification and treatment of acute illness. Over the past two years this work has drawn attention to the importance of timely escalation. This project aimed to improve consistency in the recording and response to deterioration across the country, thus enabling swifter response, which would in turn reduce the rate of cardiac arrests and the rate of preventable deaths. This project is expected to deliver up to a 5% reduction in both length of stay and cardiac arrest rate, and a 2% reduction in mortality for this cohort of patients.

Targets set for 2020/21	Status	Narrative
Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.	N/A	Due to the COVID-19 panademic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators. The sepsis project work stream continued to be monitored through the Deteriorating Patient Steering Group (DPSG) which was held sporadically over the year, progress included pushing the screening and reporting of sepsis through the use of Patientrack (electronic patient observation system).

Improving care for the deteriorating patient – Acute Kidney Injury

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

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

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

Targets set for 2020/21	Status	Narrative
Due to the COVID-19 pandemic no objectives were set for 2020/21 for this initiative.	N/A	Despite no formal targets being set for 2020/21, the AKI project work stream continued to be monitored through the Deteriorating Patient Steering Group (DPSG) which was held sporadically over the year. Progress included working on how we would alert Critical Care Outreach Teams and GPs about AKI; Plans to write SIM scenarios for areas with higher patient safety incidents involving AKI; looking at the potential for Critical Care Outreach Team (CCOT) to help ease the workload in renal; looking at the potential to use IT and the education of all healthcare workers in reducing the prevalence of AKI.

Reduction in surgical site infections

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

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

Targets set for 2020/21	Status	Narrative
Implement findings from GIRFT Surgical Site Infection Survey	N/A	Due to the Covid-19 pandemic the GIRFT work streams were intermittently placed on hold and our regional GIRFT manager redeployed until June 2021.

Reducing mortality

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

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

The aim of this work stream has been the implementation and embedding of the National Guidance on Learning from Deaths and also to be at the forefront of the national Medical Examiner programme.

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

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

Targets set for 2020/21	Status	Narrative
Due to the COVID-19 pandemic no objectives were set for 2020/21 for this initiative.	N/A	Despite no formal targets being set for 2020/21, the reducing mortality project work stream continued to be monitored through the Trust wide Mortality Review Group (TMRG). Although standardised mortality ratio's like HSMR and SHMI are not designed to model pandemic activity, mortality rates have been continuously monitored during the past 12 months. A review of mortality in 2020 highlighted that: • 1547 patients died in BSUH during 2020, of these 234 (15%) died within 28 days of having a positive swab for Covid-19

		• The annual number of deaths in 2020 was lower than the previous five years with 53 fewer deaths in 2020 compared to 2019. • The number of deaths in March and April were higher than predicted and the rate of crude mortality was also higher in these months. • Deaths in July and October were lower than predicted. • The proportion of male deaths as a result of Covid-19 was statistically significantly high at 63%. • 65% of the Covid-19 deaths occurred in patients aged 80 or above, this compares to 55% of the non Covid-19 deaths. • In total 140 patients died in the first wave of Covid-19. • In the 12 months to December 20 the rolling SHMI was 108.3. • In the 12 months to January 21 the rolling HSMR was 96.3.

Improving the quality of care of people at the end of life

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

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

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

The trust is continuing with this quality improvement work in end of life care. The aim being to:

Improve the quality of care for people at the end of life in acute hospitals.

Increase the opportunity to identify those patients who may benefit from a treatment escalation plan (TEP), and to ensure that the wishes of patients and those around them are taken into account. This plan may include a palliative and supportive approach, advance care planning and handover of key information between healthcare providers (which may reduce unwanted readmission and avoidable harm.)

Targets set for 2020/21	Status	Narrative
Embed the process of improving and measuring the 5 priorities of care. Data from the following sources to be triangulated to inform the improvement process: • Rolling case note audit • Responses to the bereaved carer's survey • Percentage of patients with a TEP documented • Percentage of patients with an Individualised Care Plan	N/A	Despite no formal targets being set for 2020/21, the quality improvement work in end of life care continued to be monitored through the Deteriorating Patient Steering Group (DPSG) which was held sporadically over the year. The rolling case note audit was continued; Covid mortality reviews were introduced, this is the review of patients who contracted Covid in hospital and sadly died. The reviews performed so far provide assurance in terms of the care given to these patients; End of life care symptom observation chart and alerting via Patientrack piloted at RSCH.

Rapid rule out protocol for ED patients with suspected acute myocardial infraction (excluding STEMI)

Since 2014, NICE has recommended the use of high sensitivity troponin assays in conjunction with early rule out protocols for acute myocardial infarction in people with chest pain. This project aims to raise awareness of the protocol and will lead to improvements in appropriate same day discharge, reductions in length of stay and overall patient experience. It is predicted that improved compliance could lead to overall national benefits upwards of £20m.

Targets set for 2020/21	Status	Narrative
Achieving 60% of Emergency Department admissions with suspected acute myocardial infarction for whom two high-sensitivity troponin tests have been carried out in line with NICE recommendations.	N/A	Due to the COVID-19 panademic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

Appropriate antibiotic prescribing for urinary tract infections (UTI) in adults aged 16+ years

There is well established NICE and Public Health England guidance for the appropriate prescribing of antibiotics to treat UTI's, including pyelonephritis and catheter associated infection (CAUTI). Improving the diagnosis and management of UTI's, including review of catheter use, will reduce treatment failure, the risk of healthcare associated bacteraemia, and reduce the associated length of stay.

In particular, better prescribing will improve the diagnosis and treatment of the estimated 38,000 hospital associated CAUTI's which lead to a further 2,500 catheter associated blood stream infections (CABSI) each year. CAUTI's incur 46,000 excess bed days and 1,500 deaths each year.

Targets set for 2020/21	Status	Narrative
Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	N/A	Due to the COVID-19 panademic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

Treatment of community acquired pneumonia (CAP) in line with British Thoracic Society (BTS) care bundle

The management of CAP, especially in association with winter pressures planning, has been a priority across the NHS for many years.

The care bundle, published by the BTS and aligned with NICE guidelines, sets out the discreet steps that providers need to follow and requires no additional investment or complex pathway changes. Adherence to this care bundle will reduce 30 day mortality, reduce length of stay (by up to 1 day according to estimates by the national team) and improve patient experience. Delivery will help to lessen the burden that pneumonia places on acute providers, which is currently associated with a spend of £765m and approximately 29,000 deaths each year.

Targets set for 2020/21	Status	Narrative
Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	N/A	Due to the COVID-19 pandemic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

Patient Experience

Frequent attenders in the ED – High intensity users service

Frequent attenders make up a significant percentage of all attendances. Consistent findings from cohort studies show that 'frequent attenders' to Accident and Emergency (A&E) Departments tend also to be frequent users of other health and social care facilities. Additionally, they tend to have a higher triage category, greater rates of admission, and a greater burden of chronic disease, when compared to matched groups[1]

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

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

Following on from this, BSUH implemented a High Intensity Users (HIU) Service to broaden the impact of the work of the CQUIN, and apply a multi-agency approach to frequent users to A&E (with any diagnosis).

Targets set for 2020/21	Status	Narrative
Due to the COVID-19 pandemic no objectives were set for 2020/21 for this initiative.	N/A	N/A

Cirrhosis and fibrosis tests for alcohol dependent patients

In 2016/17, more than 50,000 liver admissions were unplanned and avoidable. Improved cirrhosis testing will increase the number of liver disease diagnoses, which in time may change patient behaviour and ensure more effective treatment improving the prospects of recovery whilst supporting a reduction in the burden that liver disease places on the NHS.

This project reviews whether effective screening programmes and interventions are in place for those drinking at 'at risk' levels. This indicator focuses on improved uptake of cirrhosis tests.

Targets set for 2020/21	Status	Narrative
Achieving 35% of all unique inpatients (with at least one-night stay) with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis	N/A	Due to the COVID-19 panademic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

Case finding patients who are living with Hepatitis C (HCV) and may not be engaged in treatment/aware of their infection to contribute to the elimination of the disease by 2025

Many of the patient groups most affected by HCV are not in regular contact with healthcare services and experience significant health inequalities. This project will support the NHS commitment to achieve HCV elimination ahead of the World Health Organisation (WHO) target of 2030 and be the first country in the world to do so.

Finding and treating patients who are not aware of their HCV infection improves long term prognosis for patients and prevents onward transmission.

Targets set for 2020/21	Status	Narrative

Co-ordination of Operational Delivery Networks to work towards Hepatitis C elimination by delivering an out of hospital-based HCV Programme, liaising with stakeholders such as prisons, probation services, community pharmacies, drug and alcohol services, GPs and patient groups to identify, test and engage people living with HCV.	N/A	Due to the COVID-19 pandemic the operation of CQUINs (both CCG and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were therefore not required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.

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

Sussex and East Surry Clinical Commissioning Groups

See attached document

Healthwatch Brighton and Hove

Because of the impact of COVID-19 on the production of this year's Quality Accounts there is not the normal expectation that there will be comments provided on the content of this year's report and a response from Healthwatch is pending.

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

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, to prepare Quality Accounts for each financial year.

Annex 3 –Assurance Report on Quality

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

Because of the impact of COVID-19 on the production of the Quality Accounts the routine external auditor assurance has been suspended this year.

Based on work undertaken during 2020/21 the Head of Internal Audit has stated in their Head of Internal Audit Opinion that they "are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently"

Glossary of terms and acronyms

Care Bundle A set of interventions that, when used together, significantly improve patient outcomes.

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

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

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

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

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

Datix A web-based clinical incident reporting and risk management software for healthcare and social care organisations.

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

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

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.

IRIS The Trusts e-learning site

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

Microguide The local medical guidance app for clinicians

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

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

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

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

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

PatientTrack The software used by the Trust as an electronic observation solution to replace the paper process of recording vital signs (e.g. temperature, heart rate), calculating the Early Warning Score (EWS) and automatically alerting for a clinical response when required.

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.

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

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