Brighton and Sussex University Hospitals NHS Trust

Quality Accounts 2019-20

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What we do

Brighton and Sussex University Hospitals (BSUH) is 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 includes the Royal Alexandra Children's Hospital (RACH) and the Sussex Eye Hospital (SEH) and is also the major trauma centre for the region.

We provide district general hospital services to our local populations in and around Brighton and Hove, Mid Sussex and the western part of East Sussex; and more specialised and tertiary services for patients from across Sussex and the South East of England. The RSCH has a 24/7 Emergency Department (ED) for its local population and is also is 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.

Our 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.

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

Purpose of the Quality Account

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

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

Statement on Quality from the Chief Executive Officer

Welcome to the 2019/2020 Quality Account from Brighton & Sussex University Hospitals. This document will review our progress over the last twelve months and look forward to the next year.

I am hugely proud to be part of this organisation, working with colleagues determined to further improve the services we provide. This dedication has led to some significant achievements in the past year including the work carried out to reduce frequent attenders to the emergency department and improve the care of deteriorating patients.

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, recognising the 'huge improvements' made at the Trust since its last inspection. We are proud to have maintained many of the improvements seen last year and continue to build upon this success as we move into the new financial year.

Our Patient First programme is central to this progress, equipping staff to make improvements in line with our organisational priorities, something we describe as our True North. We have continued to roll the programme out to teams and departments this year and are currently on our eighth wave of participants including Midwifery, the Trevor Mann Baby Unit and the Critical Care Outreach team. In total, 64 teams have completed the programme since its introduction, implementing hundreds of positive changes across the Trust.

While we have seen significant improvement, we have still a way to go to reach the end of our improvement journey. Our Patient First approach, combined with the hard-work and dedication of our staff, means I am confident that this will continue through 2020 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 2020/21

This year's Quality Accounts have been produced during the unfolding of the COVID-19 global pandemic. Consequently the normal processes, discussions and collaboration that would occur during the production of this document have been seriously compromised. Whilst the obligation to produce a Quality Account this year was removed in March a decision was made to continue its production in the anticipation that the themes and content will form the basis for discussion and review latter in the year.

Inevitably there are shortcomings in this year's document, none of the data presented has been subjected to the external scrutiny of the trusts auditors, similarly, some sections have not been completed due to operational pressures on individual members of staff.

The cancellation of the February's meeting of the Clinical Effectiveness and Outcomes Group (COEG) curtailed discussions that had begun at the start of the year. Consequently the review of this year's projects and the establishment of targets for the forthcoming year have been put into abeyance. Initial discussions about focussing this year's initiatives on issues relating to admission's and discharges have also been abandoned in favour of a focus on the National projects in this year's Commissioning for Quality and Innovation (CQUIN) programme which at the present time is scheduled to commence in the second quarter of this financial year.

As in previous years the forthcoming initiatives are presented using 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 quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. This can only be improved by analysing and understanding patient satisfaction from their own experiences.
- Effectiveness of care. This means understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Just as important is the effectiveness of care from the patient's own perspective which will be measured through patient-reported outcomes measures (PROMs). Examples include improvement in pain-free movement after a joint replacement, or returning to work after treatment for depression. Clinical effectiveness may also extend to people's well-being and ability to live independent lives.

Last Year's Report

For patient experience our long-term objective is to achieve an overall Friends and Family Test (FFT) score in excess of 96%. Between February 2019 and January 2020 the inpatient score increased from 93.3% last year to 93.8% this year

For staff, our long-term objective is to be within the top 20% for staff engagement in the NHS staff survey by 2023. After being the most improved acute trust in 2018 the Trust maintained its overall score of 6.9 out of 10 which is just below the national average of 7.0.

For quality improvement the Trusts long-term objective is to be in the top 20% of NHS trusts for hospital standardised mortality ratio (HSMR) (the ratio of actual deaths to expected deaths). In the 12 months to November 2019 the Trusts HSMR was 89.84, meaning that the number of patients dying in the Trust was 10.16% lower than expected. This performance places the Trust 23rd out of 132 Trusts and therefore in the top 20%.

During 2019/20 six (five patients) cases of MRSA bacteraemia were identified against a target of zero. Root cause analysis of the cases highlighted the management of IV devices as a contributory factor in the incidents. To address this issue the IV electronic care pathway has been updated, the MRSA screening policy has been reviewed and all patients with complicated IVs are referred to the IV team for advice and support. In June a Trust wide IV audit is scheduled.

Despite the constraints of COVID-19 and the advice for pregnant women to shield, BSUH was the only trust within the Sussex Local Maternity System that continued its homebirth service and its continuity of care teams. The national target for continuity was 35% by March 2020; BSUH achieved 51.4%, meaning we have achieved the 2021 target a year early. Whilst we have not introduced any further teams, plans are in place for a further two teams in July/August.

Going Forward

Patient Safety

Patient falls and a reduction in pressure ulcers continue as two of this year's mains safety initiatives. Collectively pressure ulcers (including patients presenting with pressure ulcers) and falls account for over 3,000 incident reports each year.

Both incident types have also seen an increase in their rate of occurrence over the past 12 months. Last year the rate of falls increased by 9% from 3.38 to 3.68 per 1000 bed stay days, although it should be noted this rate is lower than the national rate of 6.62.

New national guidance on the management and reporting of pressure ulcers, along with increasing numbers of patients presenting with pressure ulcers or developing them has made the reduction and elimination of severe pressure ulcers a priority in 2020-21. Like the rate of falls; the rate of acquired pressure ulcers also increased from 1.18 to 1.20 incidents per 1000 bed days.

Although numerically venous thromboembolism (VTE) is not as frequently reported on Datix, three serious incidents in 2018-19 command that the management and monitoring of this condition remains a priority for the Trust in the forthcoming 12 months.

Two new CQUIN initiatives are also include in this year programme these are:

- 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.

Patient Experience

The initiative 'frequent attenders in the Emergency Department' delivered on last year's objectives and will continue in 2020-21, in response to Covid-19 the improving discharge project will be suspended for a year. Two new CQUINs projects have been included in the patient experience initiatives these are case finding patients who are living with Hepatitis C and cirrhosis and fibrosis tests for alcohol dependent patients.

During 2019-20 the Trust reported 774 mixed Sex breaches. The Chief Nurse has set up a task and finish group to focus on minimising breaches working towards zero tolerance.

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

Effectiveness of care

Finally, three effectiveness projects will continue in 2020-21. These include the projects on sepsis and acute kidney injury (AKI), which are two of the projects that make up our improving care under the deteriorating patient programme umbrella. The reducing mortality programme of work will also continue under the supervision of the Trust Wide Mortality Review Group (TMRG). The other project that will also continue this year is 'improving the quality of care of people at the end of life'

Three new CQUIN projects will commence at some point during the next year these are:

- 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.

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

2.2 Statements of Assurance from the Board

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 2019/20 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 2019/20 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 £531m. 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 2019/20 52 national clinical audits and 4 national confidential enquiries covered relevant health services that Brighton & Sussex University Hospitals NHS Trust provides.

During that period Brighton & Sussex University Hospitals NHS Trust participated in 100% 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 2019/20 are as follows:

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The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals NHS Trust participated in, and for which data collection was completed during 2019/20, 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	2019/20 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Adult Cardiac Surgery	Yes	Yes	100%
British Association of Urological Surgeons (BAUS) Urology Audit – Cystectomy	Yes	Yes	Ongoing
BAUS Urology Audit - Female Stress Urinary Incontinence	Yes	Yes	Ongoing
BAUS Urology Audit - Nephrectomy	Yes	Yes	Ongoing
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes	Yes	100%

National clinical audits	Eligible	2019/20 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Case Mix Programme (CMP)	Yes	Yes	100%
Elective Surgery - National PROMs Programme: Hip Replacement	Yes	Yes	96.5%
Endocrine and Thyroid National Audit	Yes	Yes	Approx. 33%
National Audit of Inpatient Falls	Yes	Yes	100%
National Hip Fracture Database	Yes	Yes	99.5%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	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 Care at the End of Life (NACEL)	Yes	Yes	100%
National Audit of Seizure Management in Hospitals (NASH3)	Yes	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy)	Yes	Yes	<100%
National Cardiac Arrest Audit (NCAA)	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 clinical audits	Eligible	2019/20 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
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	93.9%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Yes	100%
National Gastro-intestinal Cancer Programme: Oesophago-Gastric Cancer Audit	Yes	Yes	65 - 74%
National Joint Registry (NJR)	Yes	Yes	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 (NOD)	Yes	Yes	16.1%
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Smoking Cessation Audit	Yes	Yes	100%
National Vascular Registry	Yes	Yes	Approx 95%
Neurosurgical National Audit Programme	Yes	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Ongoing
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	100%
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	Yes	<100%

National clinical audits	Eligible	2019/20 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Surgical Site Infection Surveillance Service	Yes	Yes	100%
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
UK Parkinson's Audit	Yes	Yes	100%
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes	100%
Care of Children in Emergency Departments	Yes	Yes	100%
Mental Health - Care in Emergency Departments	Yes	Yes	100%

National confidential enquiries	Eligible	Participated	Percentage submitted
Acute Bowel Obstruction	Yes	Yes	100%
Long Term Ventilation	Yes	Yes	50%
Out of Hospital Cardiac Arrest	Yes	Yes	100%
Dysphagia in Parkinson's Disease	Yes	Yes	Ongoing

The reports of 52 national clinical audits were reviewed by the provider in 2019/20 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
Congenital Heart Disease Audit	The service is currently under review with the national team to establish continuing arrangements for the Trust to be a Level 2 provider for Congenital Heart Disease
National Audit of Breast Cancer in Older People	We run a combined geriatric and surgical clinic for this group of patients, which is an example of good practice.
VTE Prophylaxis in Lower Limb Immobilisation	The audit indicated that patients were not routinely receiving written information. Therefore clearly written patient information leaflets are to be developed and put in place in the Emergency Department.
National Cardiac Arrest Audit	All cardiac arrests are reviewed by the department to determine frequency and the outcomes of events. Lessons learnt from events are shared with departments and during mandatory training; for example: recognition of deterioration and appropriate escalation

Title	Action taken or planned
National Audit of Care at the End of Life	The Trust's End Of Life Care (EOLC) Steering Group coordinates several schemes aimed at improving services throughout the Trust. A rolling case note audit has been put in place to provide a continuous means of measuring and improving aspects of end of life care that were included in the national audit. In addition, an EOLC quality scorecard has been developed, and the results are presented regularly to the steering group, where actions are agreed in order to make improvements where necessary. The team also oversees a bereaved carer's survey, reviews the responses and provides any feedback received back to the appropriate clinical teams with learning points highlighted where relevant. The team has also led the Treatment Escalation Planning (TEP) project, which seeks to ensure that clinical teams are able to identify those patients who may benefit from a treatment escalation plan, and which may include a palliative approach, and put this into place.
National Audit of Dementia	We are continuing to deliver education around delirium assessment and the use of delirium assessment in the single clerking proforma used at the RSCH, and will be rolling out the single clerking proforma at the PRH. In the future, we may consider the use of Patientrak (an electronic patient observations package) to complete the delirium assessment. Junior doctor (Foundation 1 & Foundation 2) teaching on dementia will include the importance of communicating clear and comprehensive information in the discharge summary to primary care. The team will also focus on increasing delirium assessment and identification at the PRH. Improved links with local community services and local care homes are being developed by the dementia team which will enhance communication on discharge. The dementia team are being involved in the planning of changes to environments in different hospital areas where there are a high level of people living with dementia accessing the service. The team also conduct regular audits of the use and completion of the "This is Me" document across patient areas; this document includes individualised information about factors that can cause distress or agitation to patients with dementia and what steps that can be taken to prevent these. The Dementia Action Alliance (DAA) are now part of the Trust's Dementia Steering Group and we are working with the DAA in Haywards Heath to see if the deep community (people living with dementia) can be part of a wider group advising us on our hospital services in relation to living with dementia. There are also plans to provide a carers support group in Brighton and we are working with the DAA to see what the most appropriate need is.
National Audit of Inpatient Falls	Inpatient falls are discussed at weekly safety meetings and we have reintroduced After Action Reviews (AAR's) for all falls. The Datix reporting structure is also being changed to gain deeper understanding of events that lead to falls. 'Call before you fall' posters have been put up in toilets on the orthopaedic wards, reminding patients to call for assistance when needed.

Title	Action taken or planned
National Audit of Seizure management in Hospitals	An education session has been developed from the audit findings and presented to clinical staff in the Emergency Department.
National Diabetes Audit	The latest report for the core audit showed that the Trust performed in the top 15% of trusts. A peer review of the footcare service has been undertaken and is hoped will lead to an increase in staffing levels. Other developments include: joint working with the dietetics team to allow patients to carbohydrate count; development of a diabetes patient information leaflet; touch the toes documentation to prevent inpatient diabetes ulcers; an insulin self-administration pilot; improving data collection for the NaDIA Harms audit through encouraging all staff to report diabetes harms via the Datix system; and conducting a data review of neonatal hypoglycaemia and ethnic minority access to diabetes-antenatal services.
National Emergency Laparotomy Audit	A new joint surgical-anaesthetic NELA pathway was implemented from April 2019, and we have redesigned the theatre booking form to highlight the importance of risk assessment. We have noted improvements in the last year to our proportion of high-risk cases (=5% predicted mortality) having both a consultant surgeon and anaesthetist present in theatre; and our proportion of highest-risk cases (>10% predicted mortality) being admitted to critical care post-operatively. A further joint general surgical-anaesthetic Quality Safety Patient Experience meeting is planned where we are scheduled to discuss Morbidity & Mortality, bookings process and quality improvement initiatives.
National Hip Fracture Database	Information in the Fractured Neck of Femur proforma has been revised regarding avoidance of operative delays for patients on Direct Oral Anti-Coagulants; Yellow name badges have been provided for all members of staff on the Fractured Neck Of Femur unit so that visually impaired patients and patients with dementia can identify the people looking after them more easily.
National Neonatal Audit Programme	We have undertaken a review of the chronic lung disease guideline, developing changes to clinical care and have initiated the Vermont Oxford database to track improvements. We are also using a local quality improvement initiative (Patient First and Foremost) to focus on improving admission temperature.
National Prostate Cancer Audit	We are using published peer reviews to inform patients of side effects prevalence and ensure they receive appropriate counselling and management.
National Smoking Cessation Audit	The respiratory team will develop and roll out some trust wide re-education regarding smoking cessation interventions, delivering it to junior doctors and teams across various specialties
National Vascular Registry	We are seeking to improve referral to treatment times through increased communication regarding access to theatre and anaesthetic review.
Sentinel Stroke National Audit Programme	The Stroke Unit has achieved A-Band status. We are continuously working on initiatives to decrease direct admission times to the unit, decrease the times to see specialist staff, and reduce the length of stay on the hyperacute stroke unit.

Title	Action taken or planned
Spotlight Psychotropic Medication Audit	The dementia team will create an intranet Microguide page regarding antipsychotic prescribing in dementia, with expected standards. The team will also aim to standardise the use of pain assessment scores on dementia wards. A local spot audit of antipsychotic prescribing and a questionnaire to prescribers is to be carried out this year, with the aim of removing any barriers to improving practice. The team will also work to identify the most appropriate standardised assessment tool (there are several) to adopt, and pilot it on the dementia ward. This will be important so that target symptoms can be recorded and then any subsequent change, following treatment, can be measured.

The reports of 45 local clinical audits were reviewed by the provider in 2019/20 and Brighton & Sussex University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Specialty	Project Title	Actions to improve the quality of care
Renal	Non transplant immunosuppression audit	This audit showed the importance of ensuring that a patients' blood-borne viruses status is known before commencing immunosuppression. There is an ongoing action to develop a unit protocol on management of this.
Renal	Autosomal Dominant Polycystic Kidney Disease (ADPKD) audit	The actions resulting from this audit included a review of the recording of primary renal diagnosis for all ADPKD patients, as new terminology is in use. A more in depth review is planned in the next audit of referral and genetic clinic data.
Anaesthesia and Acute Pain	Evaluation of the Enhanced Recovery Programme (ERP) analgesia for total knee replacements (TKR)	As a result of this audit our TKR ERP analgesia guidelines were updated.
Anaesthetics and Acute Pain	Audit of the current usage of McKinley pumps and the inappropriate use of epidural instead of nerve block pumps with nerve catheters	As a result of this audit a business case has been submitted to purchase 10 new, and replace 7 old, nerve block pumps.
Anaesthetics and Pharmacy	Sugammadex (neuromuscular reversal drug) usage.	A new policy has been written and submitted and is currently awaiting approval.
Anaesthetics and Ophthalmology	To understand the reasons for late cancellations and evaluate whether the pre-assessment policy for general anaesthetic /intravenous sedation in the Sussex Eye Hospital is fit for purpose	A pre-assessment policy for reviewing patients' blood pressure was developed. After implementation of this policy the number of cancellations due to high blood pressure dropped to 2%.
Anaesthetics	Audit of the availability of emergency anaesthetic drugs.	As a result of this audit Pharmacy have since re-arranged supplies of relevant drugs to clinical areas.

Specialty	Project Title	Actions to improve the quality of care
Vascular Surgery	Vascular surgery admission clerking: a quality improvement project and observational study	This audit highlighted the pitfalls of freestyle/plain paper clerking and showed that a detailed clerking proforma for surgical admissions is urgently required in order to meet the basic standards set out by the Royal Colleges.
Acute Pain	Pain Controlled Anaesthesia (PCA) policy compliance	The audit findings were shared with all nursing staff completing these charts at all educational opportunities. Anaesthetic staff were reminded to prescribe Naloxone as per the Trust policy.
Neurology	Headache audit	As a result of this audit a business plan was submitted for the recruitment of a headache and community nurse.
Acute Pain	Audit of the Enhanced Recovery After Surgery (ERAS) pain pathway for knee replacements	Patients receiving Gabapentin and adductor canal blocks had a reduced length of stay and better quality pain management. As a result we will continue to use Gabapentin pre-operatively and train more anaesthetists to do adductor canal blocks.
Transplant Outpatients	Transplant audit	Decision to continue to develop a definitive database of all transplants and present survival/outcome data, as well as adherence to protocols. New electronic checklists for donor/recipients to be developed to reduce data entry errors and reduce the amount of nursing time spent entering the data.
General Surgery	Improving surgical induction for Junior Doctors in General Surgery	Actions post audit included updating the general surgical guidebook with the aid of FY1 Doctors and Senior House Officers (SHO's). An email was sent to the Head of Surgery with important points to cover following feedback from the juniors. An electronic folder on the Team Drive was created for induction resources, including an induction video for those unable to attend induction in person. There was a clarification of duties at the PRH for SHO's. The audit results were highlighted at the Local Faculty Group meeting.
Renal Surgery	Nephrectomy / Heminephrectomy audit	A clinical pathway / guideline for all patients will be written alongside input from the Paediatric Surgeons.

Specialty	Project Title	Actions to improve the quality of care
Obstetrics	Epidural bag size on the labour ward	The decision was made to change to 250mls epidural bags for labour analgesia as this has been shown to have significant cost savings and increased patient safety factors.
Cancer	Re-audit of patient satisfaction on Multi-Disciplinary Team (MDT) clinics	As a result of this audit an information board will be placed at reception notifying patients of the waiting time for each clinician/clinic.
Gynaecology	Laparoscopic hysterectomy audit	Current management of laparoscopic hysterectomy at PRH complies with National and NICE guidelines. Minimal access surgery should be offered to all patients as the route of choice for hysterectomies. These findings were presented at the June 2019 audit meeting.
Orthodontics	An audit assessing dental recall and fluoride use in orthodontic patients.	We are considering the development of a departmental information leaflet and having a display board in the patient waiting room. We will continue sending post-brace fit letters to the General Dentist Practitioners and providing verbal and written instructions. We will re-audit in 12-18 months due to the patient recall time interval.
Microbiology	A prospective audit of antimicrobial stewardship and 'Start Smart – then Focus' compliance on a vascular ward.	Despite the improvement seen in current practice the audit has shown the requirement for more teaching to increase awareness, such as including the results of this audit in the Junior Doctors' induction materials. We suggest that a trust-wide audit is carried out to reflect on the current practice in different departments. The need to highlight the importance of keeping the start date of the antibiotic the same when the drug chart is rewritten to ensure we know how long the patient has been on the antibiotic. A proposal will be made to amend the current drug chart so that a specific tick box is created for comorbidities that may affect antibiotic dosage/duration.

Specialty	Project Title	Actions to improve the quality of care
Orthopaedics	Audit to assess performance of Orthopaedic Clinical Governance meetings against Royal Collage Standards (RCS)	Action to remind SHO's/Registrars at induction of the clinical governance meeting standards. Remind all to use the RCS clinical governance meeting template proforma. Action to identify someone to act as the meeting coordinator. Introduce the use of an individual record for each case discussed to allow clear identification of actions. Consider how best to record morbidity and mortality trends within the department.
Acute pain	Auditing documentation compliance against the Local Anaesthetic Policy	To emphasise in teaching sessions the importance of 4 hourly observations including site checks. To email all anaesthetists with the audit findings for information.
Ear, Nose and Throat (ENT)	Myringotomy and grommet insertion consent audit	NICE guidelines need consistent implementation; patient consent taking best practice should include a discussion of the use of hearing aids before grommet insertion.
Thyroid Surgery	Vocal cord injury in thyroidectomy patients.	A new pathway will be implemented to automatically book post-operative laryngoscopies for all patients via the ENT department.
Emergency Department	Epistaxis pathway service improvement	A new pathway was implemented based on the audit findings. Significant bed savings were made. Further research is needed to investigate further cost savings initiatives and to improve patient experience.
Paediatric Surgery	Doctor - Nurse handover book in Paediatric Surgery	The audit showed that the Doctor-Nurse communication axis was improved by the implementation of a handover book. Further recommendations include the evaluation and use of a mobile phone to create a direct line from the ward to the surgical team.
General Surgery	General Surgery use of Emergency Ambulatory Care Unit (EACU) and how it could be improved	Actions included; increase awareness of the EACU referral form amongst surgical teams; teaching sessions on how to use the EACU referral form; posters put up in the Surgical Team Office to serve as a reminder.
Cancer	Chest stage 1 and 2 cancer treatment in performance status (PS) 0-2	The results of the audit were fed back to the Multi-disciplinary Team (MDT) and the MDT was educated on the importance of accurate PS recording.

Specialty	Project Title	Actions to improve the quality of care
Endocrinology and Cancer	Acromegaly surgical outcomes	The data from this audit will be reported quarterly at the pituitary MDT. Thus providing a continuous rolling audit of patient outcomes.
Endocrinology	Imaging for patients with primary hyperparathyroidism.	As recommended by this audit it was agreed to change to neck ultrasound scan as 1st line imaging; and to only proceed to isotope scan if the disease is not localised; for other imaging only once discussed at the MDT. Recommendations disseminated via the MDT meeting.
Pharmacy	Safe prescribing: inpatient drug chart audit	The audit showed the importance of ensuring that start dates and indications for antibiotics are included on prescription charts. The results were disseminated via an audit meeting.
Diabetes	Diabetes Mellitus management at end of life care	A flow chart was developed and added to the Trust's Microguide.
Vascular	Vascular access audit	The findings from this audit identified the need for a review of theatre list usage to remove factors outside our control and to review the 28% of patients cancelled/unfit to identify if pre clerking would have prevented these cancellations. The audit highlighted the poor data quality of vascular access in electronic patient records. All dialysis patients' primary access was consequently reviewed in the electronic database.
Renal	Haemodialysis audit	The findings from this audit identified the need to establish a working group to standardise working practices across the units and to involve staff in moving away from paper towards electronic records. There is a plan is to introduce a mandatory 'machine assigned' field to help traceability and activity in the future and to make further changes to the electronic documentation to make it easier for staff to record pre/post session information.
Vascular Surgery	Vascular Surgery operation notes: a quality improvement project and observational study	Intended interventions will comprise of teaching sessions and the introduction of a new standardised departmental operation template proforma.

Specialty	Project Title	Actions to improve the quality of care
Dieticians	Use of the nasogastric (NG) tube care bundle and compliance with the Trusts policy to reduce harm associated with misplaced NG tubes.	The audit findings were presented to the Acute Dietetics team to highlight the need to promote use of the NG care bundle when starting any new patient on NG feeding.
Dieticians	Use and accuracy of the malnutrition universal screening tool (MUST) in adult inpatients.	Audit findings were discussed at the Nursing & Midwifery Board meeting. Action plan to be agreed with Nursing Leads; including better use of the MUST module on IRIS (the Trusts e-learning site); a focus on documenting 3-6 month weights in Nutrition & Hydration Week; and engaging nutrition link nurses.
Renal	Home therapies audit	This audit highlighted that the recording of administrations of Aranesp for home haemodialysis patients is not kept electronically. The plan is for patients to return paper prescription sheets so administrations can be entered onto an electronic database. Action to add on to the transfer checklist for returning transplant patients, when/if the patients peritoneal dialysis catheter was removed; thus avoiding patient records showing a patient having a peritoneal dialysis catheter still in situ despite it being removed at the transplant centre.
Neurology	Immunotherapy audit	Suitable information regarding each immunosuppressive agent used in neurology should be provided to patients in order that they are adequately informed and able to share in the decision making regarding medication choice, and to promote self-management. Either local or alternative sources of information for patients are already available for most drugs but it is not always easy to find. All drug information resources should be collated into a single online folder with an additional hard copy library. Provision of this information should be prospectively recorded. Results to be presented to the Department before instituting a departmental guideline.
Neurology	National audit of seizure management in hospitals	The audit findings were presented at the ED Clinical Governance meeting; and to ED Specialist Registrars in an educational / teaching session.

Specialty	Project Title	Actions to improve the quality of care
Obstetrics	Management of confirmed ectopic pregnancies	Audit findings showed that timings of repeat scans are being missed and that conservatively managed patients did not have their hormone levels checked as per protocol. The recommendations made included booking an ultrasound scan for 1 weeks' time for all conservative managements as soon as the decision is made. To give patients having conservative management blood forms for both 48 and 96 hour bloods as soon as the decision is made. To email the guidelines around repeat scan times and hormone level follow up to all Doctors/Early Pregnancy Unit (EPU) staff. Provide EPU staff teaching sessions with a focus on ectopic pregnancy management at the next new doctors induction. The findings were presented at the July 2019 Audit meeting.
Renal	Hypertension audit	Recommendation made to review all patient 'Did Not Attend' (DNA) appointments within the service and to develop a pre-populated target blood pressure that is editable so it is included in every clinic letter to GP's. These actions are ongoing.
Neonatal	Twins And Multiple Births Association (TAMBA)/ Multiple pregnancy audit	Changes and cost savings through reduced neonatal admissions can be made at zero cost by introducing a multiples clinic by rescheduling multiple appointments to the same day; Implementing the NICE endorsed TAMBA care pathway; a sonography protocol to ensure positional labelling of foetuses. Findings presented at the June 2019 Audit meeting.
Dietician	An evaluation of a pilot intensive messy play programme for severely orally sensory sensitive children	Our intervention showed a positive impact on at least one area of each of the participant's behaviour. The audit was submitted to The British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) 2020 as an abstract. An oral presentation was given at the National Conference in January 2020. Dissemination of results.

Specialty	Project Title	Actions to improve the quality of care
Dietician	A pilot study to investigate the prevalence of abnormal nutritional bloods in exclusively enterally fed neurologically impaired children	Compliance with The European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) guidance on the assessment of micronutrient status requires improvement in our centre. This could be improved by prioritising certain nutrients as it would appear the successful collection of multiple nutrients is problematic. Audit submitted to BSPGHAN 2019 as an abstract. Dissemination of results.
Ear Nose Throat	Patient feedback in the ENT outpatients – A closed loop audit of patient perception	In the first cycle 89% of responses were 'very good'. Improvements introduced included ensuring the doctor clearly stated their name and role at the beginning of the consultation; permission to examine was clearly stated 'I need to examine…..is that ok?' and the reason behind the examination was given; an explanation of the treatment was given including taking the time to use the leaflet and ask patients if what had been said made sense/ any further questions? Post these improvements in the second cycle 98% of responses were 'very good'. Further actions include another cycle to refine all areas of consultation; gather more long term cumulative data in a specific clinic; test other clinical areas such as patients in A&E and pre-op; look at focusing on improving qualitative data specifically

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 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 3318.

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

A proportion of Brighton & Sussex University Hospitals NHS Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Brighton & Sussex University Hospitals NHS Trust's and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Statements from the Care Quality Commissioner (CQC)

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

The Care Quality Commission has not taken enforcement action against Brighton and Sussex University Hospitals NHS Trust during 2019/20

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 2019/20 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 2019 to January 2020):

Which included the patient's valid NHS number was:

99.4% for admitted patient care:

99.8% for outpatient care and

96.6% for accident and emergency care

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

99.9% for admitted patient care;

100% for outpatient care; and

99.4% 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. Whereas the Trust was on target to submit this fully and on time by 31 March 2020, the outbreak of COVID-19 has understandably displaced operational priorities. That, and a national agreement from NHS Digital (NHSD), which runs the DSPT, is likely to result in a delayed submission. NHSD has agreed that during the COVID-19 situation submissions can be made, without negative sanctions, up to 30 September 2020. Positively, however, to reinforce the message that the Trust was intending to submit a compliant DSPT, its internal auditors gave a Substantial Assurance finding, following the audit in February 2020. This substantiates detailed work undertaken by the Trust's Information Governance Team, whereby it assures itself, the Information Governance Steering Group and The Trust that effective Information Governance and Data Protection processes are in place. This includes an annual self-assessment audit programme covering the General Data Protection Regulation 2016 / Data Protection Act 2018, its own peer review of the DSPT, and spot checks of clinical areas across all Trust sites.

Clinical Coding Error Rate

Brighton & Sussex University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2019-20 by the Audit Commission.

Data Quality

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

- **Internal training**: Creation and distribution of Data Quality awareness e-learning module alongside refresh of patient identification e-module course. The Corporate Data team

arrange regular training for ward admin and reception staff to ensure data capturing skills are honed and shared.

- **Internal data quality reporting**: Data Quality Improvement Group held quarterly to share learning across various fields (IT, System Management, Clinical staff, IQ team, ward managers, etc.) to enhance understanding of data quality issues and solutions as they arise and build supportive networks for staff that engage with data collection and management. Update and evolve Data Quality Suite to ensure appropriate and clear reporting is always available. Continue working with data owners to address the Data Quality Improvement Strategy actions. Organise clear reporting of data quality incidents and offer targeted learning to areas or staff that need it when raised through these reports. Work closely with data collection areas (e.g. A+E reception) to ensure processes staff follow are valid and fit for purpose. Produce quarterly DQ reports for the Information Governance Steering Group.
- **National data quality reporting**: Continue to assist departments with weak data reporting to reach national targets.
- **Demographic Batch Service (DBS)**: Run twice daily trace against NHS spine on all triggered patient records to trace/validate NHS Number and GP Practice, and assist staff in ensuring correct patient records are used.

Learning from Deaths

Deaths in 2019/20

During 2019 /20 1642 of Brighton & Sussex University Hospitals NHS Trust patients died (of which 29 were neonatal deaths/stillbirths, 7 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:

- 361 in the first quarter (of which 7 were neonatal deaths/stillbirths, 3 were people with learning disabilities and 0 had a severe mental illness).
- 328 in the second quarter (of which 6 were neonatal deaths/stillbirths, 0 were people with learning disabilities and 0 had a severe mental illness).
- 450 in the third quarter (of which 7 were neonatal deaths/stillbirths, 4 were people with learning disabilities and 2 had a severe mental illness).
- 503 in the fourth quarter (of which 9 were neonatal deaths/stillbirths, 0 were people with learning disabilities and 1 had a severe mental illness).

Mortality Reviews

By 31 March 2020, 59 case record reviews and 2 investigations have been carried out in relation to 61 of the deaths.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 30 in the first quarter;
- 16 in the second quarter;
- 11 in the third quarter;
- 4 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
0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

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

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

Investigations into 3 deaths in the reporting period remain ongoing at the time of writing.

Learning from case record reviews and investigations
There were no patient deaths during the reporting period judged to be more likely than not to have been due to problems in the care provided to the patient, so this section is not relevant.

Action following our learning
There were no patient deaths during the reporting period judged to be more likely than not to have been due to problems in the care provided to the patient, so this section is not relevant.

The impact of our actions
There were no patient deaths during the reporting period judged to be more likely than not to have been due to problems in the care provided to the patient, so this section is not relevant.

Mortality reviews relating to deaths during the previous reporting period
43 case record reviews and 7 investigations completed after 31 March 2019 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
3 representing 0.18% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using root cause analysis to conduct a full serious incident investigation

Revised estimate of deaths judged to be more likely than not to have been due to problems in care during the previous reporting period
5 representing 0.3% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Implementing the Priority Clinical Standards for 7 Day Services

Brighton and Sussex University Hospitals Trust has made good progress in implementing the four priority clinical standards and is now fully compliant for all admitting specialities.

Performance in the most recent 7 day services survey, undertaken in November 2019 is detailed in the tables below:

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

This equals the performance in spring 2018 for patients admitted as an emergency, receiving a thorough clinical assessment by a suitable consultant within 14 hours of admission to hospital.

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

There is no change from the spring 2018 survey where all diagnostic tests were noted to be available on site.

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 6:Consultant Directed Interventions			
Critical Care	Yes available on site	Yes available on site	Standard met
Interventional Radiology	Yes available on site	Yes available off site via formal arrangement	
Interventional Endoscopy	Yes available on site	Yes available on site	

Emergency Surgery	Yes available on site	Yes available on site	
Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
Urgent Radiotherapy	Yes available on site	Yes available on site	
Stroke Thrombolysis	Yes available on site	Yes available on site	
Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
Cardiac Pacing	Yes available on site	Yes available on site	

There is no change from the spring 2018 survey where all consultant directed interventions were noted to be available on site or offsite via formal arrangement.

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 8:Ongoing Daily Consultant Reviews			
Once daily review	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard met
Twice daily review	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

This represents an improvement in overall performance when compared to the spring 2018 survey as the Trust are now achieving full compliance in all four areas of this standard.

Staff Who Speak Out

Staff members have a number of channels available to them to speak up about issues or concerns they have, particularly those relating to quality of care, patient safety, and bullying or harassment. Brighton and Sussex University Hospital NHS Trust works 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 is actively inviting staff to speak up and contribute to discussions and activities to improve both patient and staff experience.

The Trust's Freedom to Speak Up Guardian has been in post for 3 years and works with individuals teams and groups to promote speaking up. This includes regular sessions at 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 routinely reports to the Trust Board.

During 2019 the National Guardian's Office reviewed speaking up in the Trust and commented that;

> *"The review found evidence that the Trust was in the process of making improvements to its speaking up culture and that its leaders were focussed on the importance of positive working cultures in the delivery of high-quality patient care."*[1]

The 2019 staff survey has shown a 0.9% increase in staff saying they feel secure raising a concern about unsafe clinical practice bringing the score within 0.4% of the national average. The Trust continues to exceed the national average with its 1.6% 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 0.2 behind the National Average score of 6.7.

Brighton and Sussex University Hospital NHS Trust is promoting a culture which encourages staff to speak up. In the first instance, all staff are directed towards their line manager/supervisor/team leader. Understanding the importance managers 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. Staff additionally have support from the Freedom to Speak Up Guardian, access to a listening and support service called Connections; HELP a psychotherapy service; staff networks; and the Diversity and Inclusion Team.

Rota Gaps and Plans for Improvement

A report from the Guardian of Safe Working Hours was not available at the time of producing these accounts.

2.3 Reporting Against Core Indicators

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

The majority of core indicators are reported by financial year, e.g. from 1st April 2018 to 31st March 2019, however some indicators report on a calendar year or partial year basis. Where indicators are report on a non-financial year time period this is stated in the data table. It is important to note that some national data sets report in significant arrears and therefore not all data presented are available to the end of the current reporting period (31st March 2020).

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.

[1] https://www.nationalguardian.org.uk/wp-content/uploads/2019/11/20190619-brighton-and-sussex-university-hospitals-nhs-trust-a-case-review-of-speaking-up-processes-policies-and-culture.pdf

Indicator **Domain**	Summary Hospital-level Mortality Indicator Preventing people from dying prematurely				
BSUH 2019	National average 2019	Best performing Trust 2019	Worst performing Trust 2019	BSUH 2018	BSUH 2017
97.68% ***As expected***	100% ***As expected***	68.49% ***Lower than expected***	120.12% ***Higher than expected***	97.94% ***As expected***	98.93% ***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 (November 2018 - October 2019)

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 2019	National average 2019	Highest performing Trust 2019	Lowest performing Trust 2019	BSUH 2018	BSUH 2017
2.4%	1.8%	3.7%	0.6%	1.82%	1.17%
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

Table based on latest available data (November 2018 - October 2019)

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.

The most recently published adjusted health gain figures available are finalised data covering the period 2018/19. Below are the adjusted average health gain figures for the EQ5D outcome measures.

Indicator Domain	Patient Reported Outcome Measures EQ 5D Index (casemix adjusted health gain) Helping people to recover from episodes of ill health or following injury					
Type of Surgery	BSUH 2018/19	National average 2018/19	Best performing Trust 2018/19	Worst performing Trust 2018/19	BSUH 2017/18	BSUH 2016/17
Hip replacement	0.464	0.457	0.503	0.395	0.439	0.399
Knee replacement	0.314	0.337	0.361	0.292	0.317	0.284
Data Source	https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms					

Latest available data (2018/19, finalised data published Feb 2020)

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 carrying out dedicated washing and dressing assessments in the Orthopaedic Treatment Centre and introducing 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 2019	National average 2019	Best performing Trust 2019	Worst performing Trust 2019	BSUH 2018	BSUH 2017
Patients aged 0 to 17 years	8.28%	10.06%	4.49%	15.06%	8.90%	8.46%
Patients aged >18 years	8.58%	8.44%	4.94%	12.28%	8.56%	8.58%
Data Source	Activity and Readmission Data produced using Healthcare Evaluation Database					

Table based on latest available data (November 2018 – October 2019)

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 2019/20	National average 2019/20	Best performing Trust 2019/20	Worst performing Trust 2019/20	BSUH 2018/19	BSUH 2016/17
67.6%	67.2%	86.2%	54.4%	67.8%	67.4%
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 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 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 2019	National average 2019	Best performing Trust 2019	Worst performing Trust 2019	BSUH 2018	BSUH 2017
66.1%	70.5%	87.4%	39.7%	67.7%	57.9%
Data Source	NHS Digital http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RXH_full.pdf				

Table based on latest available data (2019)

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 2019/20	National average 2019/20	Best performing Trust 2019/20	Worst performing Trust 2019/20	BSUH 2018/19	BSUH 2017/18
93.8%	96.6%	99.7%	78.72%	93.3%	95.3%
Data Source	NHS England				

Table based on latest available data (February 2019 to January 2020)

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 2019/20	National average 2019/20	Best performing Trust 2019/20	Worst performing Trust 2019/20	BSUH 2018/19	BSUH 2017/18
91.2%	95.5%	100.0%	71.8%	92.6%	93.1%
Data Source	NHS Digital https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/				

Table based on latest available data (Quarter 1, 2 and 3 for 2019-20)

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

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

Rate of *C.difficile* infection

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

Indicator **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 2019/20	National average 2019/20	Best performing Trust 2019/20	Worst performing Trust 2019/20	BSUH 2018/19	BSUH 2017/18
18.52	15.34	3.39	34.68	16.1	19.0
Data Source	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure				

Table based on latest available data February 2019 to January 2020

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 2018/19	National average 2018/19	Best performing Trust 2018/19	Worst performing Trust 2018/19	BSUH 2017/18	BSUH 2016/17
I	41.76	46.29	99.69	27.76	38.95	36.63
ii	0.04	0.15	0.53	0.01	0.07	0.09
iii	13	38	135	2	20	27
iv	0.10%	0.31%	1.34%	0.01%	0.17%	0.25%
Data Source	NHS Improvement https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-data/					

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 12,036 in 2018-19 to 12,196 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

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.

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

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

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

The objectives set for 2019/20 for this initiative were partially achieved:

Targets set for 2019/20	Status	Narrative
The rate of newly acquired pressure ulcers in 2018/19 was 1.18 incidents per 1000 bed stay days. The target for 2019/20 was a reduction of 10% or a rate of 1.06 incidents per 1000 bed stay days.	Not Achieved	339 acquired pressure ulcers were reported in 2019/20 at a rate of 1.2 per 1000 bed stay days
In 2018-19 13 patients acquired a grade 3 or 4 pressure ulcer. The target for 2019-20 was no more than 10.	Achieved	Five grade 3 pressure ulcers were reported. However, it should be noted the new guidance on pressure ulcers was issued during

Targets set for 2019/20	Status	Narrative
		2019 and unstageable incidents should be counted alongside grade 4 and 4 pressure ulcers. During the past 12 months 25 unstageable pressure ulcers were reported.
In 2017-18 74% of the pressure ulcers reported occurred in the community. The target for 2019/20 was to establish a forum with Sussex Community NHS Foundation Trust to explore areas of collaborative working.	Achieved	The joint forum has continued to meet regularly during 2019-20.

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
TBC	April 2021

Falls prevention

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

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

The objectives set for 2019/20 for this initiative were not met.

Targets set for 2019/20	Status	Narrative
Maintain the 2018-19 rate of 3.38 falls per 1000 bed stay days.	Not Achieved	The falls rate in 2019-20 was 9% higher at 3.68 falls per 1000 bed stay days.
Achieve the CQUIN target of 80% of all older inpatients receiving key falls prevention actions	Not Achieved	The target of 80% was missed as only 15% of patients received all the key falls prevention actions

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
TBC	April 2021

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).

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

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

The objectives set for 2019/20 for this initiative were partially achieved

Targets set for 2019/20	Status	Narrative
Undertake a structured judgement review into all PE deaths post discharge.	-	Because of the time lag on the comparative database that the Trust subscribes to no post discharge PE deaths occurred in 2019/20
Improvement in the 2018-19 root cause analysis rate of 53.6% for hospital acquired VTE.	Achieved	At the start of April 136 RCA's had been undertaken with 36 cases requiring a review (review rate 79%). The majority of cases where a review is outstanding are from February and March
Improvement in the 2018-19 rate of 2.3% avoidable hospital acquired VTEs	Not Achieved	The rate of avoidable VTE's for 2019/20 is 5.9%
Review the VTE related emergency readmissions data in order to develop a plan to reduce this to lower than the national average. In 2018-19 the Trust rate was 0.11%.	Not Achieved	The readmission rate for the 12 months May 2019 was 0.12%. This data has been routinely produced for the Thrombosis Committee
Meet the CQUIN target of 50 – 75% of eligible patients presenting to A&E to be managed in a same day setting.	Achieved	100% of patients presenting to A&E met the target

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
TBC	April 2021

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

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.

Target	By when (date)
Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE Guideline (NG) 24.	March 2021

Supporting the anti-microbial resistance agenda by better targeting the usage of Antifungals (new project)

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.

Target	By when (date)
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.	March 2021

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.

Our 2019-2020 sepsis improvement work has continued to focus on the early recognition and prompt escalation of patients who present to the Emergency Department, or deteriorate on the wards as an inpatient. The sepsis Clinical Nurse Specialist (CNS), educates all clinical staff on induction to the trust to ensure a standardised approach to sepsis knowledge. Regular study days are conducted inviting survivors of sepsis to present their journey to staff to provide a greater insight and improve awareness.

BSUH have successfully deployed an electronic observation solution (E-Obs) Trust-wide to record and calculate National, Pediatric and Maternal Early Warning Scores. This has demonstrated huge

benefits for patients with increased monitoring and improved communication and has received positive feedback from clinicians due to it saving time and providing a better audit trail. As part of this roll out an electronic sepsis screening tool has been implemented in all adult inpatient areas, automatically triggering when a NEWS2 score of 5 or more is generated. This prompts the staff to consider sepsis in this cohort of patients, improving screening, early detection and escalation of patients.

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

The objectives set for 2019/20 for this initiative were partially achieved

Targets set for 2019/20	Status	Narrative
100% of patients screened for sepsis (who met the screening criteria)	Achieved	The Trust fully achieved the target of sepsis screening of all patients.
90% of antibiotics given within one hour of diagnosis.	Partially achieved	86% of ED patients received IV antibiotics within 1 hour of sepsis diagnosis. For inpatients, of the sample audited, 77% of patients received IV antibiotics within 1 hour of diagnosis which has seen an improvement with the introduction of electronic screening tools.

This initiative will continue in 2020/21:

For 2020/2021 a deteriorating patient CQUIN has been initiated which focuses on the recording of NEWS2 score, escalation time and response time for critical care admissions. This will have an impact on sepsis recognition as the data collection tool will include the question; was this patient screened for sepsis, if confirmed sepsis, were they treated with antibiotics within one hour.

There are approximately 52 adult wards throughout the Trust, all of which are provided with sepsis awareness and education by the Sepsis CNS. With huge variation in prevalence of sepsis and equivalent variation in demand within the role, there is a need to sustain continuation of auditing by ward areas providing their own surveillance of sepsis. With the introduction of E-Obs every patient treated for sepsis has a flag applied highlighting

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 aims to improve consistency in the recording and response to deterioration across the country, thus enabling swifter response, which will in turn reduce the rate of cardiac arrest 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.

Target	By when (date)
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.	March 2021

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

The objectives set for 2019/20 for this initiative were **[achieved/partially achieved/not met]**

Targets set for 2019/20	Status	Narrative
Deliver interruptive alerts to acute trust and primary care for AKI 1 and 2 with hyperkalaemia and all AKI 3		Information not available at the time of completing this document
Engage with the BSUH Kaizen (continuous improvement) Team as sponsors for ward/departmental implementation		
Critical Care Outreach Team deployment of AKI tools and resources		
Deployment of AKI medication review in specialist and medical divisions		

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
TBC	April 2021

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.

The objectives set for 2019/20 for this initiative were achieved

Targets set for 2019/20	Status	Narrative
Identify the surgical site infection rates of specific procedures within key surgical specialties.	-	The Trust is currently waiting to receive its GIRFT Surgical Site Infection Survey Pack
Achieve the CQUIN target of 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines	Achieved	Compliance for colorectal antibiotic prophylaxis is 92%

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
Implement findings from GIRFT Surgical Site Infection Survey	April 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

The aims for 2019/20 were to focus on strengthening practice in the areas identified by the CQC and furthermore to:

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

The objectives set for 2019/20 for this initiative were partially achieved:

Targets set for 2019/20	Status	Narrative
Increase the proportion of SJRs undertaken from 12.47% in 2018-19	Not achieved	2.23% of all hospital deaths were subjected to an SJR in the past 12 months.
Increase the proportion of SJRs reporting positive scores for 'overall assessment' from 56% in 2018-19	Not achieved	The proportion of SJRs reporting positive scores for 'Overall Assessment' has decreased to 47%. This is the result of case selection. We have focussed our attention on cases where concerns have been raised. The care in these cases is therefore more likely to be rated lower.
Decrease the proportion of SJRs reporting problems in care from 40% in 2018-19	Achieved	Proportion of SJRs reporting problems in care has reduced to 34%. This section asks questions about specific areas of care such as diagnosis and infection control. Due to small numbers it is not possible to identify which areas of care have directly contributed to the improvement.

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
TBC	April 2021

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."

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

The Trust 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.)

The objectives set for 2019/20 for this initiative were partially achieved:

Targets set for 2019/20	Status	Narrative
75% of patients leaving the Acute Floor (discharged or moved to a specialty ward) to have a TEP documented.	Partially achieved (ongoing)	55% of patients leaving the Acute Floor were recorded as having a TEP documented. The treatment escalation planning project has evolved to incorporate all of BSUH as there has been more interest from different departments. There have been Plan-Do-Study-Act (PDSA) cycles on the respiratory and renal units, led by a Core Medical Trainee in the Palliative Care Team. The next plan is to run PDSA cycles in the oncology and care of the elderly specialties. Within the Acute Floor the TEP was originally in the single clerking document, however it was identified during the commencement of the project that the TEP process is more likely to occur once the patient is admitted to a speciality (i.e. further down the pathway).
All clinical areas to have the new Trust TEP guidance and education plans established.	Partially achieved (ongoing)	There are quality improvement plans (including education) for the areas identified above. The Patient First Improvement System (PFIS) is being utilised to embed the TEP in new areas and overcome any obstacles to implementation.
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	Partially achieved (ongoing)	A rolling case note audit has been in place since August 2019 and has been presented to the Trust Board. The percentage of TEPs documented is monitored as part of the rolling audit and also monitored as part of the Trusts Deteriorating Patient Breakthrough Objective. Responses to the bereaved carers survey remains low in numbers, but any feedback received is reflected back to the appropriate teams. In order to triangulate this data, an End Of Life Care (EOLC) Quality Scorecard has been produced, and the results are

		reviewed at the EOLC Steering Group, and actions taken on any improvements identified. The focus for the next year is to continue the work of ensuring patients have a Treatment Escalation Plan, and to increase awareness of the Individualised Care Plan for the Dying Patient.

This Initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
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	April 2021

Trauma Outcomes

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

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

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

The objectives set for 2019/20 for this initiative were partially achieved

Targets set for 2019/20	Status	Narrative
Establish a scrutiny panel to review the clinical management of every 'code red' patient (i.e. a patient with clinical evidence of significant traumatic haemorrhagic shock)	Not achieved	Progress has been delayed whilst clinical governance funding was being identified. Funding to support this target has now been established and the post is being advertised
Systematically undertake a SJR into every trauma death.	Achieved	Every trauma death is reviewed in the monthly ED trauma governance meeting.
Develop a trauma outcomes scorecard combing data from Trauma and Audit Research Network (TARN) with information collated from clinical incidents, complaints	Not achieved	See above re funding

and Healthcare Evaluation Data.		
Establish a monthly Trauma Governance Meeting to: • Progress multi-disciplinary collaborative working • Discuss the findings from the scrutiny panel • Review the outcome from the SJRs • Scrutinise the trauma scorecard • Refine clinical pathways • Update the Board monthly	Partially achieved	The Trauma Governance meeting has reviewed all deaths and ways of working.
Introduce and start using the code red structured clinical review tool	Not achieved	See funding issue above.

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

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.

Target	By when (date)
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.	March 2021

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

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.

Target	By when (date)
Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	March 2021

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

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.

Target	By when (date)
Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	March 2021

Patient Experience

Improving Hospital Discharge Planning Project

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

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

It is well known that there are many benefits to patients being discharged effectively from the hospital setting to the community setting including; a reduction in hospital acquired infection, optimised rehabilitation, and improved patient experience. Improving hospital discharge planning would in turn increase patient flow through the acute bed base resulting in acutely unwell patients being placed in the right place at the right time, creating a safer environment for patients throughout their hospital journey

The objectives set for 2019/20 for this initiative were partially achieved

Targets set for 2019/20	Status	Narrative
To see a 25% reduction in the number of complaints relating to hospital discharge	Not achieved	The number of formal and informal complaints increased in 2019-20 from 112 in 2018-19 to 124 in the past 12 months.
To see a 25% reduction in safeguarding alerts relating to hospital discharge	Not achieved	Last year 24 safeguarding alerts recorded an issue relating to hospital discharge. This year the figure rose to 46.
Reducing the number of patients with a length of stay of over 21 days by 40%'	Not achieved	Last year 2949 patients had a length of stay that was greater than 21 days, this year the figure was 1 higher at 2950
To see a 25% increase in discharges before midday	Not achieved	The number of patients discharged before midday increased by 1.2% this year from 24.3% in 2019-18 to 25.5% in 2019-20
To see a decrease in the number of patient safety incidents in relation to discharge. In 2018-19, 34 discharge planning incidents were submitted and 23 were submitted in relation to inadequate discharge information.	Achieved	This year 54 patient safety incidents were reported, 31 related to discharge planning and 23 were reported in relation to inadequate discharge information.

Frequent Attenders in the Emergency Department – 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[2]

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.

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).

The objectives set for 2019/20 for this initiative were achieved.

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

Targets set for 2019/20	Status	Narrative
Arrange at least quarterly meetings of the High Intensity Users Multi-Disciplinary Team	Achieved	Effective meetings happening monthly with good BSUH and external organisation representation.
Review the needs of patients identified, and in collaboration with relevant agencies, generate enhanced care plans for these patients.	Achieved	Ongoing process of multidisciplinary review of 1) our most frequently attending patients 2) those identified by staff in real time where review and intervention by the HIU service could support them (these may not be patients with the highest number of attendances.) Creation of 20 MDT-approved, accessible guidance documents to support the management of frequent attenders of particular concern. Involvement in improving discharge of homeless patients working group. Bolstered communication between organisations between meeting so that we speak regularly as soon as there are any developments / concerns with frequently attending patients. This allows the system to work in a more responsive and integrated manner for these patients. Agreed metrics to begin evaluation of the work. Working closely with the Clinical Commissioning Groups (CCG) on development of the business case and procurement process for the city-wide HIU service planned.
Reduce attendances for the top 70 users of the Emergency Department (between November 2017 and October 2018) by 20%	Achieved	No longer working solely on top 70 - need was recognised to pick up focus on new referrals / people starting to increase their attendance again (fitting the criteria of 10 or more attendances in 12 months) Success of now having dedicated ED Consultant, ED Senior Nurse and ED Fellow support to bolster the work and focus on impact.

This initiative will continue in 2020/21:

Targets for 2020/21	By when (date)
TBC	April 2021

Cirrhosis and fibrosis tests for alcohol dependent patients (new project)

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.

Target	By when (date)
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.	March 2021

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 (new project)

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 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.

Target	By when (date)
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.	March 2021

3.2 Performance against the relevant indicators and performance thresholds

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

	Performance against the NHS Oversight Framework			
	2019/20 (April 2019 – Feb 2020)	Improvement threshold 2019/20	2018/19 (April 2018 – Feb 2019)	2017/18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	70.07%	92%	73.66%	83.12%
A&E: maximum waiting time of 4hours from arrival to admission/ transfer/ discharge	80.74%	95%	83.10%	84.28%
All cancers: 62-day wait for first treatment from:				
a) urgent GP referral for suspected cancer	69.5%	85%	71.25%	76.6%
b) NHS Cancer Screening Service referral	74.5%	90%	68.25%	69.6%
C. difficile: variance from plan	Reported in 2.3 core indicators			
Summary Hospital-level Mortality Indicator	Reported in 2.3 core indicators			
Maximum 6-week wait for diagnostic procedures	11.99%	1%	20.12%	6.06%
Venous thromboembolism (VTE) risk assessment	Reported in 2.3 core indicators			

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

Sussex and East Surry Clinical Commissioning Groups

Healthwatch Brighton and Hove

Because of the impact of COVID-19 on the production of this year's Quality Accounts, a draft copy of the Quality Accounts has been sent to partner organisations without the normal expectation that they comment on the content of this year's report.

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 - 2019-20's, the routine external auditor assurance has been suspended this year.

Glossary of terms and acronyms

After Action Review (AAR) Is a discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened, what went well and what can be improved. AAR is a timely intervention that seeks to understand the expectations and perspectives of all those involved. It generates insight, lessons learned and leads to greater awareness, changed behaviours and agreed actions.

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.

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

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.

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

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

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

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