



Brighton and Sussex
University Hospitals
NHS Trust

Quality Accounts 2017-18

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Part 1: Statement on quality from the Chief Executive Officer

What we do

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital working across two main sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital (PRH) in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital (RACH) and the Sussex Eye Hospital and is also the Major Trauma Centre for the region. We provide District General Hospital services to our local populations in and around Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients from across Sussex and the South East of England. The Princess Royal Hospital has a 24/7 Emergency Department (ED) for its local population and is also our centre for elective surgery. The Royal Sussex County Hospital is our centre for emergency and tertiary care.

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

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

Purpose of the Quality Account

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

Ten Facts about the Trust

In 2017-18, the Trust:

- 1) Employed 8,900 members of staff
- 2) Had 3,500 patients volunteering to take part in one of the 179 clinical research projects being conducted at our hospitals in Brighton and Haywards Heath
- 3) Cared for 45,000 children from across the South East in our Royal Alexandra Children's Hospital
- 4) Treated 60-80 radiotherapy patients a day in our state of the art cancer care centre in Eastbourne District Hospital
- 5) Excavated enough soil and chalk to fill 40 Olympic swimming pools as part of our 3Ts redevelopment project
- 6) Celebrated 10 years of life-saving transcatheter aortic valve implantation (TAVI) heart surgery, a minimally invasive surgical procedure which repairs the valve without removing the old damaged valve, avoiding the need for open heart surgery in 800 patients
- 7) Installed a world-first HIV testing kit vending machine in Brighton Sauna over 200 kits were dispensed in the first six months
- 8) Delivered 5,370 babies
- 9) Had 173,109 people attend A&E
- 10) Treated 45,478 people as day cases

Statement on quality from the Chief Executive

Welcome to the 2017/2018 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.

During 2017/18, we rolled out our 'Patient First' improvement programme, empowering our staff to take new approaches to improving our patients' care. 13 wards have already taken part in the Patient First coaching and are using its simple, effective, structure to improve the service we can offer our patients. Eight more wards are being trained over Summer/Autumn 2018 with further wards planned for the winter.

We already have many successes to celebrate.

For example, in A&E, over 90% of blood test results are now available in under an hour, reducing waiting time and speeding up treatment decisions. Unnecessary processes have also been eliminated, helping A&E patients see a consultant faster, and be treated or discharged sooner.

Thanks to colleagues' hard work over eight years, every single one of our wards now has a falls rate below the national average. Jowers Ward and Level 9a had the lowest number of falls across the trust (1.24 and 1.45 per 1000 bed stay days), and Emerald Ward reduced their falls by more than half in twelve months.

Investment in our stroke unit means that we can now offer treatment seven days a week and chemotherapy treatment at Princess Royal is now offered five days a week. More of our good news stories are highlighted within the Best of BSUH.

At a corporate level, we are working with Good Governance Institute to ensure clear lines of sight from the front line of service delivery through to board level on quality and safety. This means that we can identify – and resolve – issues much earlier, contributing to the improvements in patient care.

We are also expanding the coverage of the Friends and Family Test in order to ensure the patients voice is included in our decision making process.

Much has changed for the better since we were placed into Special Measures by the Care Quality Commission in 2016/17. We aren't at the end of the journey, but through the hard-work and dedication of our staff, we have made measurable improvements in quality and patient care across the trust in the last year. I am confident that these will continue through 2018 and beyond.

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



Marianne Griffiths – Chief Executive

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

2.1 Priorities for improvement in 2018/19

The Patient First approach - Vision, Priorities and Objectives

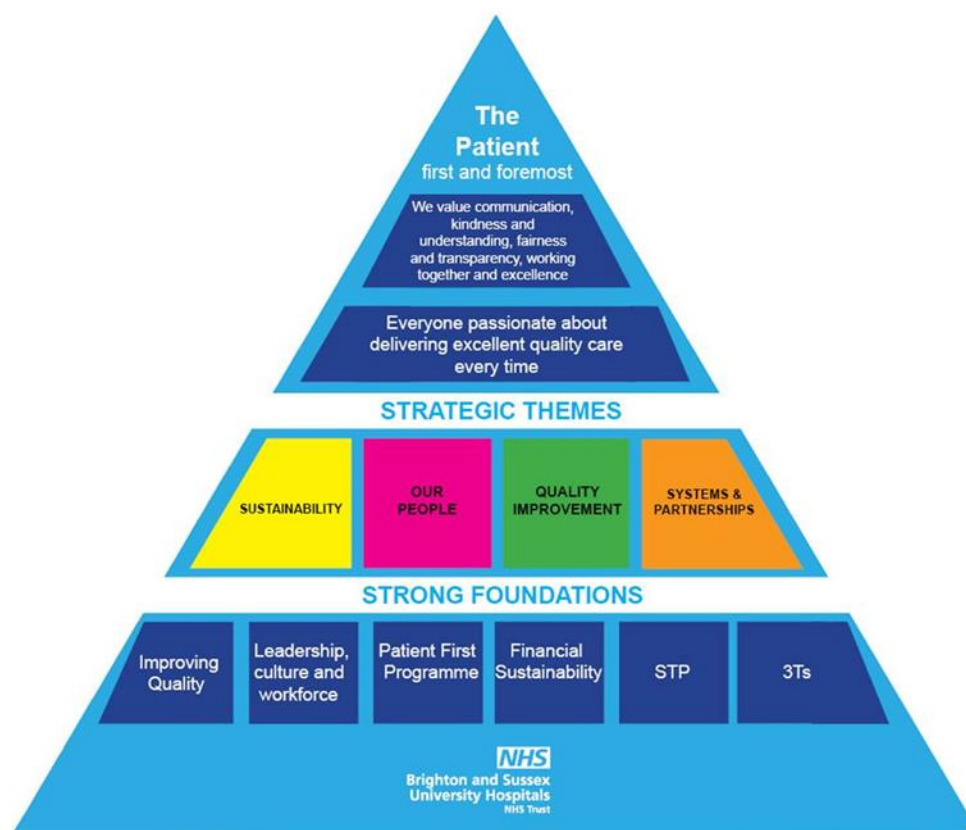
“Everyone passionate about delivering excellent quality every time”

We recognise that the strength of our hospitals lies in our staff, and we are building an organisational culture that empowers teams and individuals to make lasting changes that benefit our patients and community. To do this, we have developed Patient First – the Trust's bespoke approach to sustaining a culture of continuous improvement.

This approach was introduced to BSUH in 2017-18 as part of a long-term approach to transforming hospital services. Whether it's small steps or complex change, **Patient First** is a continuous process of improvement within existing processes and pathways that leads to measurable improvements for our patients and staff.

It is all about empowering front-line staff to make improvements themselves by providing the training, the tools and the freedom to work out where the opportunities are; and the skills and support to make sustainable change happen.

The Patient First triangle has been created to explain the different layers of the Patient First Programme.



The patient is at the apex of the triangle to make it explicit that everything we do should contribute to improving the experience and outcomes of the people in our care. This is the True North of the organisation, the one constant to which we must always set out direction of travel in order to achieve our vision.

Patient First has four strategic themes that guide the initiatives we put in place across the Trust:

- **Our people**
- **Quality improvement**
- **Sustainability**
- **Systems and partnerships**

Each of the strategic themes has a number of **breakthrough objectives** that will take us furthest and fastest towards our overall True North.

This means that:

- Our True North focus around the **PATIENT** is on patient experience
- Around **OUR PEOPLE**, it's about improving staff engagement
- In **QUALITY IMPROVEMENT**, it's reducing mortality and avoiding harm
- For **SUSTAINABILITY**, it's on managing our budget
- And for **SYSTEMS AND PARTNERSHIPS**, it's improving patient flow.

True North Domain	Breakthrough Objective	Executive Lead
Patient	Reduction in negative feedback where staff attitude is cited as an issue	Chief Nursing Officer
Sustainability	Achieve the Efficiency plan for 2017/18	Chief Financial Officer
People	Staff believe that care is the top priority for the organisation	Chief Workforce Officer
Quality	Improvement in recognition and management of deteriorating patients	Chief Medical Officer
Systems & Partnerships	Reduction in the numbers of patients waiting longer than 4 hours in A&E who are not admitted	Chief Delivery Officer
	Ensure no patients wait over 52 weeks for elective treatment	Chief Delivery Officer

The Patient First triangle also illustrates the **strong foundations** on which the programme must be built and for BSUH these are:

Improving quality, underpinned by financial sustainability, the best leadership, culture and workforce. In addition, we need to play our part in our local Sustainability and Transformation Programme and ensure we progress our 3Ts redevelopment of the Royal Sussex County Hospital site.

The delivery of the Patient First Programme is supported by **five pillars**, which support the strategic themes and will help us achieve our objectives:

1. **Kaizen office** – Kaizen is a Japanese concept that, loosely translated, means continuous improvement. The principle is at the heart of the philosophy that made Toyota and others,

including the Virginia Mason Medical Centre, so successful and sustainable. It is about getting front-line staff to approach problem-solving and root cause analysis from a different, ceaselessly inquisitive perspective.

2. **Patient First Improvement Systems (PFIS)** – the PFIS is the Lean management programme designed to develop our people’s ability to solve problems and improve performance. During the programme, teams receive specialist training and coaching to introduce tools and techniques that will help eliminate waste from everyday processes and begin to improve them on a continuing basis.
3. **Capability** – The Patient First Capability Programme provides the skills and training necessary to help teams understand and use the principles and tools of continuous improvement .
4. **Improvement projects** – our improvement approach involves using “Lean” principles pioneered by Japanese car producer Toyota after the Second World War. Lean is a systematic method of eliminating waste from a process. In a hospital setting, examples of waste could include moving patients from department to department or ward to ward unnecessarily, holding more supplies than we actually need, or delays in discharge or diagnostic tests.
5. **Strategy deployment** – where theory becomes reality. Strategy deployment is the process through which we identify and review the True North objectives for each strategic theme and cascade these throughout the organisation. It provides a framework to enable staff at all levels to be clear about our priorities, our progress against them and how best they can contribute.

Priorities for Improvements 2018-19

The Patient – True North objective: an overall score of over 96% for patient experience when measured through the Friends and Family Test.

Our long-term objective is to achieve an overall Friends and Family test score in excess of 96%. In the medium term, we want to reduce the number of occasions where staff attitude is cited as an issue. Currently our A&E score is 90%, 4% higher than the England average, while our inpatient score is 96%, in line with the England average.

Our People – True North objective: to be in the top 20% in the country for staff engagement.

Our long-term objective is to achieve a staff engagement score within the top 20% of Trusts in the NHS Staff Survey. The NHS Staff Survey is a comprehensive tool for exploring the experiences of staff working at BSUH. In the medium term, we want to increase the percentage of staff who believe that care is this organisation's top priority. In the last year, the staff survey score for "I believe care is this organisation's top priority" has increased by 4%, from 64% in 2016 to 68% in 2017. Levels of staff engagement are low due to inconsistent leadership, poor CQC ratings and a long-term lack of investment in the hospitals and services. This is changing, our Executive Team, led by Chief Executive, Marianne Griffiths, has been in place for one year with a commitment for at least another two years. The Executive Team has reviewed leadership structures across the Trust, appointed new senior leaders and is investing in their learning and development to provide better organisational leadership.

The 3Ts hospital redevelopment is a £485 million project to replace some of the NHS's oldest buildings and provide purpose-built, future-ready clinical facilities. These will enable existing staff to provide high quality care more easily, while making the organisation more attractive for new recruits.

Quality Improvement – True North objective: to be in the top 20% of NHS trusts for preventable mortality and provide 100% harm free care.

Our long-term quality objective is to be in the top 20% of NHS Trust for hospital standardised mortality ratio (the ratio of actual deaths to expected deaths) and provide harm free care, as measured by the NHS Safety Thermometer (a monthly tool that collects data on four harms: pressure ulcers, harm from falls, urine infection (in patients with a urinary catheter) and new VTE.

In the medium term we are focused on improving our recognition and management of deteriorating patients in order to help us achieve our aim of being in the top 20% of Trusts for HSMR. We are running campaigns throughout our hospitals to educate staff on the prevention of pressure sores.

On our Emerald Unit for dementia care, the team's dedicated falls prevention campaign has reduced patient falls by 67% to below the national rate in the last year.

Sustainability – True North objective: to reduce our deficit until we balance our budget.

Our long-term sustainability objective is to balance our budget. In the medium term, we are committed to annual budget plans that reduce our deficit. In 2017/18 we met our control target. As an NHS organisation, there are multiple risks to meeting our control targets, from national changes and restructures to meeting local staffing needs and the increasing costs of goods and services. Our control targets take these risks into account and we have plans in place for dealing with financial uncertainties.

Systems and Partnerships – True North objective: to have 95% of A&E patients waiting less than four hours to be admitted or discharged; and to reduce referral to treatment below 18 weeks for 92% of patients.

Our long-term systems and partnerships objectives are to have 95% of A&E patients waiting less than four hours and to maintain a referral to treatment (RTT) time below 18 weeks for 92% of patients. In the medium term, we are concentrating on reducing the numbers of patients who visit A&E and wait over four hours and then aren't admitted and are committed to ensuring no patients wait over 52 weeks for elective treatments.

Trust performance for RTT increased to 87% in July 2017/18, but following significant emergency pressures in the winter of 17/18 we undertook a planned reduction in routine elective inpatients to ensure clinically urgent, cancer and emergency patients were prioritised. This impacted on RTT performance which by year end was 83.1%.

A&E performance was also challenging throughout 2017/18. However, the Trust achieved an on average 2% improvement in their performance throughout the year relative to 2016/17 (including Brighton Station Walk in Centre). The Trust has worked collaboratively with partners, developed estate, and enhanced internal process improvements through a nationally recognized Kaizen improvement programme, which will continue to mature and deliver improvements into 2018/19.

2.2 Statements of assurance from the Board

Relevant Health Services and Income

During 2017/18 Brighton and Sussex University Hospitals NHS Trust provided acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups and NHS England. £504m of our income came from Clinical Commissioning Groups and NHS England for patient care activity. The income generated by the NHS services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of NHS services by Brighton and Sussex University Hospitals NHS Trust for 2017/18.

Each of our 5 Clinical Divisions and the specialties within them reviews the data available to them on the quality of care in their services. To support this we implemented a Safety and Quality dashboard for each of the Clinical Divisions containing standard information on patient safety, clinical effectiveness and patient experience.

Participation in clinical audits and confidential enquiries

During 17/18 47 national clinical audits and 5 national confidential enquiries covered relevant health services that Brighton & Sussex University Hospitals NHS Trust provides.

During that period Brighton & Sussex University Hospitals NHS Trust participated in 43 out of 47 national clinical audits and all 5 national confidential enquiries.

The national clinical audits and national confidential enquiries that Brighton & Sussex University Hospitals NHS Trust was eligible to participate in during 17/18 are shown in Appendix 1.

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 17/18, are listed below in Appendix 1 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.

The reports of 33 national clinical audits were reviewed by the provider in 17/18 and the main points of action that Brighton & Sussex University Hospitals NHS Trust intends to take to improve the quality of healthcare provided are shown in Appendix 1. Reports of national clinical audits are disseminated to the Trust's Clinical Specialties for their actions.

The reports of 40 local clinical audits were reviewed by the provider in 17/18 and the main points of action that Brighton & Sussex University Hospitals NHS Trust intends to take to improve the quality of healthcare provided are shown in Appendix 2. Reports of local clinical audits are disseminated to the Trust's Clinical Specialties for their actions.

Participation in clinical research

Brighton and Sussex University Hospitals NHS Trust is committed to carrying out clinical research to find the best treatments and cures for a range of chronic diseases and illnesses, benefiting patients locally and nationally. A wide range of research was carried out last year across 22 clinical specialities of which our priority areas were Paediatric Respiratory Medicine, Cancer, Cardiovascular Disease, HIV Medicine, Neurological Disorders, Orthopaedic Surgery, Rheumatology and Renal Disorders.

The number of patients receiving relevant health services provided or sub-contracted by Brighton and Sussex University Hospitals NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee 4491.

Our research team were actively recruiting patients to a total of 179 projects over this period.

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

Use of the Commissioning for Quality and Innovation (CQUIN) National goals payment framework

A proportion of Brighton & Sussex University Hospitals NHS Trust's income in 2017/18 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 2017/18 and for the following 12 month period are available electronically at:

<https://www.bsuh.nhs.uk/about-us/>

Statements from the CQC

Brighton and Sussex University Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against Brighton and Sussex University Hospitals NHS Trust during 2017/18.

The CQC conducted an inspection of the Trust in April 2017. The inspection was to determine if the Trust had made progress against the Improvement Plan following the previous inspection in April 2016 where the Trust was rated as inadequate and subsequently placed in Special Measures by NHS Improvement.

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

Improvement Plan

The new Trust Executive Team reviewed the Improvement Plan in April 2017 and agreed to present evidence to support compliance to the Oversight Committee over the following 12 months. In addition, the Improvement Plan was updated to reflect the areas where the CQC gave a Regulatory notice. Progress against compliance is reported monthly to the Quality Improvement and Assurance Group and Trust Board.

CQC Engagement

The CQC local inspection team meet with the Trust monthly as part of on-going engagement to review progress against the Improvement Plan and Regulatory Notices. A programme of engagement visits, starting in April 2018, has begun and a visit to each core service has been arranged. The CQC local inspection team request data prior to their visit, meet the senior management team of the core service to discuss improvements and challenges since the visit in April 2018, visit the area and meet with staff. These engagements visits will form part of the intelligence which will feed into the fully comprehensive inspection in 2018.

NHS Number and General Medical Practice Code Validity

Brighton and Sussex University Hospitals NHS Trust submitted records during April 2017 to February 2018 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data.¹

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.3% for admitted patient
- 99.6% for out-patient care
- 93.4% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.9% for admitted patient care
- 99.9% for out-patient care
- 99.7% for accident and emergency care

Information Governance Toolkit attainment levels

Brighton & Sussex University Hospitals NHS Trust's Information Governance Assessment Report overall score for 2017/18 was 66% and was graded green (satisfactory).

Clinical coding error rate

Brighton & Sussex University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2017-18 by the Audit Commission.

Data Quality

Brighton & Sussex University Hospitals NHS Trust will be taking the following actions to improve data quality. The Clinical Networks team have, and will continue to, develop strong collaborative working links across clinical, administrative, coding and finance teams to improve on the accuracy of coded data.

Currently over 95% of Clinical Services have identified a Consultant Coding Lead who meets with the coding team each month to validate and correct their coded data. This entails an hour spent reviewing patient level coding and includes data correction, feedback to clinical teams regarding improved documentation and additional training for coding staff where required.

This initiative has proved highly successful in engaging consultants and enabled clinicians to understand, review and take ownership of their coded data. As well as improving coding of activity, the reviews have highlighted clinical variations and differences in pathways and it has also enabled more accurate benchmarking with other organisations.

¹ Please note that in the Brighton & Hove area in the last year we have had at least three GP surgery closures. The local Clinical Commissioning Group (CCG) left it to Patient Choice as to where to re-register. Regrettably we have a large cohort of attending patients who still haven't registered with an alternative Practice. Therefore their General Medical Practice Code remains as "Not Registered".

Learning from Deaths

The following elements are newly added for 2017/18 as part of the 'Learning from Deaths' updates made to the Quality Accounts regulations.

QA section	Statement
27.1	<p>During 1 April 2017 to 31 March 2018 1638 of Brighton & Sussex University Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:</p> <p>379 in the first quarter; 334 in the second quarter; 455 in the third quarter; 470 in the fourth quarter.</p> <p>Stillbirths delivered from 24 weeks and neonatal deaths after 22 weeks (not included above)</p> <p>During 1 April 2017 to 31 March 2018, there were 39 Stillbirths delivered from 24 weeks and neonatal deaths after 22 weeks. This comprised the following number of deaths which occurred in each quarter of that reporting period:</p> <p>15 in the first quarter; 9 in the second quarter; 7 in the third quarter; 8 in the fourth quarter.</p>
27.2	<p>By 31 March 2018, 48 case record reviews and 8 investigations have been carried out in relation to 55 of the deaths included in item 27.1.</p> <p>In 1 case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:</p> <p>15 in the first quarter; 19 in the second quarter; 17 in the third quarter; 5 in the fourth quarter.</p>
27.3	<p>5 representing 0.3% 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.</p> <p>In relation to each quarter, this consisted of:</p> <p>2 representing 0.5% for the first quarter; 1 representing 0.3% for the second quarter; 1 representing 0.2% for the third quarter; 1 representing 0.2% for the fourth quarter.</p> <p>These numbers have been estimated using root cause analysis to conduct a full serious incident investigation.</p>

QA section	Statement
27.4	<p>Learning from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.</p> <p>Clinicians should have a low threshold of suspicion for bowel ischaemia in patients with a history of bariatric surgery and particularly in those who are pregnant. Patients should be managed urgently.</p> <p>Current bariatric guidance should be reviewed to ensure preferred imaging modality for pregnant patients which should be performed urgently.</p> <p>Obstetric guidance should be developed to ensure appropriate care management arrangements for pregnant patients with other clinical needs. This should include guidance on fetal monitoring.</p> <p>Further training and raising awareness of the complications of bariatric surgery, particularly in the pregnant patient, should take place. Arrangements should be made for urgent access to imaging for pregnant patients with a history of bariatric surgery.</p> <p>As a result of the inquest this investigation now recognises that the management of the patient's wound was a significant contributory factor in the patient's death.</p> <p>A review of the Standard Operating Procedure for Compartment Syndrome is being undertaken to include non –traumatic Injury. Guidelines on bandaging and the management of leg bleeding are being written. The use of the type of compression bandaging used for this patient has ceased</p>
27.5	<p>Actions taken and proposed to take as a result of learning identified (see item 27.4)</p> <p>Review and reissue current bariatric guidelines to ensure clarity regarding the most appropriate and accessible imaging which should be performed urgently.</p> <p>Develop obstetric guidelines for the appropriate care management of a pregnant patient who also has other clinical needs. This should include guidance on fetal monitoring.</p> <p>Review junior doctor and registrar induction to ensure inclusion of complications of bariatric surgery</p> <p>A review of the Standard Operating Procedure for Compartment Syndrome is being undertaken to include non –traumatic Injury. Guidelines on bandaging and the management of leg bleeding are being written. The use of the type of compression bandaging used for this patient has ceased</p> <p>Ensure reissued bariatric guidelines are made widely available</p> <p>Provide training on registrar study days</p> <p>Discuss and agree arrangements with the Imaging department for urgent access to CT/MRI for pregnant patients with a history of bariatric surgery</p> <p>Share incident with MRI radiographers to ensure correct understanding of safety checks for patients with surgical clips.</p> <p>Ensure consistent practise regarding checking MRI safety questionnaire on ward prior to patient attending the department</p> <p>Arrange review/training session with nursing staff regarding Trust transfer policy</p> <p>Ensure nursing staff made aware of the appropriate NEWS chart that should be used</p> <p>Review process and explore standardisation e.g. using a template</p> <p>Review processes to ensure robust and effective communication during handover</p> <p>Explore the use of a 'readback', the repetition of a message one has received, to reduce</p>

QA section	Statement
	<p>to risk of a breakdown in communication.</p> <p>Focused refresher training on the management of deteriorating patients:</p> <p>Reminder/refresher training for SAU staff regarding the regularity of blood sugar testing for diabetic patients – to be discussed at the SAU Safety Huddle meeting.</p> <p>Cease with immediate effect the type of compression bandaging used for this patient</p> <p>Update existing Standard Operating Procedure for ‘Compartment Syndrome to include Non –traumatic Injury’</p> <p>Guidelines on bandaging and the management of leg bleeding to be written – to also be included in the Registrar handbook</p>
27.6	The evaluation of these actions is currently being incorporated into the specialty quality improvement programmes for 2018/19
27.7–27.9	The prescribed information required in sections 27.7 to 27.9 of the Quality Account is not applicable as this year 1 of data collection

Implementing the priority clinical standards for 7 Day Services

BSUH is expected to fulfil the Seven Day Service standards for all admitting specialities by 2020. Current performance as per the last national audit in September 2017 is given in the table below:

	Clinical Standard 2 Time to 1 st Consultant Review	Clinical Standard 5 Access to Diagnostics	Clinical Standard 6 Consultant Directed Interventions	Clinical Standard 8 Ongoing Daily Consultant Reviews
BSUH rate	76%	100% ²	89% ³	95% for twice daily review 91% for once daily review ⁴
National Average	72.3% ⁵	95.9%	93.5%	85.2%

Key to meeting this priority is our project on patient flow which is ongoing and will result in increased capacity, quality and better patient care. This includes redevelopment of the acute floor, investment in staffing and other components such as reinforcing Hospital at Home. The project includes significant input from senior clinical leadership and has the commitment of the Executive Team and Chiefs.

Workforce planning will enable BSUH to meet the challenges of providing both initial and ongoing senior review. A new Workforce Efficiency Working Group has been established, which is Medical Director chaired and supported by the Project Management Office; this will provide oversight and

² Data from March 2017 survey. Standard 5 was not measured in Sept 2017

³ Data from March 2017 survey. Standard 6 was not measured in Sept 2017

⁴ Data from March 2017 survey. Standard 8 was not measured in Sept 2017

⁵ National Benchmark available from March 2017 survey

delivery of consultant efficiency & productivity, including sessions aligned to acute care in all specialties. It will also scrutinise and help steer senior decision maker workforce planning; both non-medical and medical (including roles such as physician assistants, surgical care practitioners and advanced nurse specialists in hard to recruit areas such as Emergency, Acute and Frailty Medicine). The recent establishment of new divisional structures and the 2018/19 senior workforce job planning round are other enablers of initial and on-going senior review.

2.3 Reporting against core indicators

As set out by NHS Digital, our data for the core mandatory set of indicators, based on recommendations by the National Quality Board, are set out below. They align closely with the NHS Outcomes Framework and are all based on data the Trust already reports on nationally.

Summary Hospital-Level Mortality Indicator

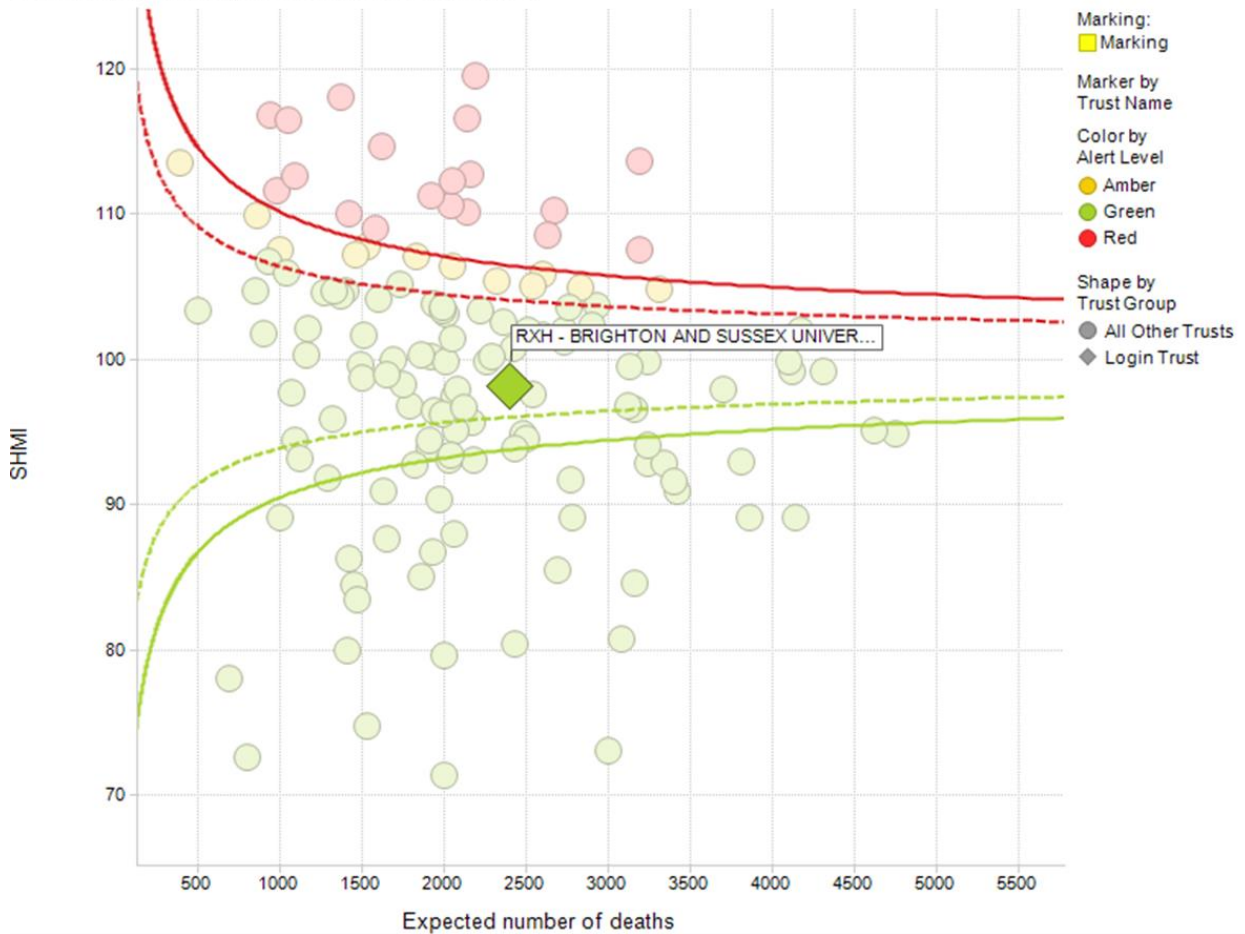
The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who died following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI gives an indication for each non-specialist acute NHS trust in England 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.

	Jan – Dec 2016	Banding	Jan – Dec 2017	Banding
BSUH rate	98.82	2	98.18	2
National average	100.00	2	100.00	2

Data Source: Healthcare Evaluation Data Base

Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons: it is taken from a national supplier. The Trust has taken actions to improve this rate, and so the safety of its services, by routinely monitoring mortality rates at the Trust Mortality Review Group. This includes looking at mortality rates by 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.

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.



Patient Reported Outcome Measures (PROMs)

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

- groin hernia surgery;
- varicose vein surgery;
- hip replacement surgery;
- knee replacement surgery.

Below are the adjusted average health gain figures for the EuroQol -5 Dimension Score (quality of life measure):

	2016-17				2017-18			
	Groin hernia	Varicose vein	Hip replacement	Knee replacement	Groin hernia	Varicose vein	Hip replacement	Knee replacement
BSUH rate	0.073	0.100	0.438	0.300	0.095	0.110	0.403	0.293
National average	0.088	0.095	0.438	0.320	0.086	0.092	0.445	0.324
Best performing hospital	0.130	0.132	0.492	0.363	0.113	0.142	0.467	0.374
Worst performing hospital	0.033	0.037	0.0376	0.0236	0.046	0.050	0.380	0.266

Data source: <http://www.hscic.gov.uk/proms>

The Trust's PROMs for both groin hernia surgery and varicose vein surgery are higher than the national average. The hip and knee replacement PROMs are however, below the national average. Local review of available data indicates that the PROMS tool is not sensitive enough to adequately account for the patient casemix at the complex end of the spectrum of hip and knee replacement patients that are treated at BSUH. Nevertheless, further detailed reviews of the data are being undertaken at present.

Patients readmitted to a hospital

The percentage of patients readmitted to any hospital in England within 28 days of being discharged from hospital after an emergency admission during the reporting period; aged:

- 0 to 15; and
- 16 or over.

0-15 Years of age	Jan – Dec 2016	Jan – Dec 2017
BSUH rate	8.08	8.19
National average	9.07	9.02
Other Trusts – highest	14.43	14.99
Other Trusts - lowest	3.67	2.86

16 Years or over	Jan – Dec 2016	Jan – Dec 2017
BSUH rate	8.35	8.31
National average	7.40	7.43
Other Trusts – highest	10.87	10.47
Other Trusts - lowest	4.26	3.93

Data Source: Healthcare Evaluation Data Base

Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons: it taken from the national dataset. The Trust routinely audits this data for accuracy.

Responsiveness to the personal needs of patients

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

	2015 -16	2016 -17
BSUH rate	68.7%	67.4%
National average	69.6%	68.1%
Other Trusts – highest	76.8%	76.1%
Other Trusts - lowest	63.7%	64.5%
Acute non-specialist trusts - lowest	49%	47%

Data Source: NHS Digital

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. An action plan that addresses the issues raised in the National Patient Survey has been developed and will focus on improvements in food, mixed sex accommodation, discharge planning and information for patients about their procedures.

Staff who would recommend the Trust to their friends and family

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

	2016	2017
BSUH rate	55%	58%
National Average Acute non-specialist trusts	69%	69%
Acute non-specialist trusts – highest	85%	86%
Acute non-specialist trusts - lowest	49%	47%

Data Source: NHS Digital

Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons: we have developed a systematic approach to the collection of the Friends and Family Test (FFT) scores. However we plan to improve our response rates to the FFT surveys in 2018/19.

We have a True North objective to improve our staff engagement score and be in the top 20% of NHS employers in future staff survey results. This is supported by the breakthrough objective, "Care of patients/service users is the organisation's top priority". In the 2017 Staff Survey results there was a significant increase in the breakthrough objective which improved by 4% from 64% in 2016 to 68%.

There were also significant increases in the two Friends and Family questions in 2017: the number of staff recommending the Trust as a place to work which increased by 5%, from 42% in 2016 to 47%, and an increase of 3%, from 55% in 2016 to 58%, of staff saying that if friends and relatives needed treatment that they would be happy with the standard of care provided by the Trust.

These results are encouraging and we are 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.

Patients who would recommend the Trust to their family or friends

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

	Inpatients % Recommending		A&E % Recommending	
	Apr 16 – Mar 17	Apr 17- Feb 18	Apr 16 – Mar 17	Apr 17- Feb 18
BSUH rate	96.12	95.27	87.61	88.59
National average	95.39	96.62	85.61	86.73
Other Trusts – highest	99.31	99.32	98.81	98.34
Other Trusts - lowest	73.47	76.30	47.85	52.32

Data Source: NHS Digital

Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons: the exercise is undertaken by an external organisation with adherence to strict protocols around sample size and selection. Improving staff experience and engagement is a key objective of the new Trust Leadership Team in 2018/19

Patients admitted to hospital who were risk assessed for venous thromboembolism

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

During 2017-18 our VTE assessment rates is these have been improved. This improvement has been down to increasing education and to the better identification of low risk cohorts as per NHS England guidance.

Performance is below the national average because with the exception of a few specialities the Trust is dependent on collecting the data via the EDS (electronic discharge summary). If the box on the EDS is not filled in that a VTE assessment is completed or if the EDS is not submitted for any reason this impacts negatively on the Trusts performance.

This amounts to a significant numbers of patients- in 2017/18 Q4 Total patients 24170, EDS empty (i.e. no outcome) 1477, No VTE risk assessment 433, Yes 22260. 6% of patients there is no outcome on the EDS as to whether they have had a VTE risk assessment.

	2016-17	2017/18 Q1 – Q3
BSUH rate	90.03	93.14
National average	95.53	95.27
Other Trusts – highest	99.94	99.37
Other Trusts - lowest	79.14	78.14

Data Source: NHS Digital

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

Rate of C.difficile infection

This looks at the rate per 100,000 bed days of Trust apportioned cases of *C. difficile* infection that have occurred within the Trust amongst patients aged 2 or over during the reporting period.

	2016 - 17	2017 - 18
BSUH rate	17.1	17.1
National average	13.2	*
Other Trusts – Best performing	0.0	*
Other Trusts - Worst performing	82.7	*

* National data for the period 2017-18 not available at time of publication

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 completed investigation is reviewed bi-weekly by the Trust’s RCA Review Group, which includes the Co-ordinating Commissioner. The Trust’s rate is higher than the national average; there were three spikes during 2017-18, it has not been possible to identify any trigger for these spikes at this time. There will be a continuing focus on hand hygiene practice, cleanliness and anti-microbial stewardship in 2018/19.

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

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

- i) rate of incidents reported per 1000 bed days
- ii) rate of incidents 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.

	Oct 15 – Sep 16				Oct 16 – Sept 17			
	(i)	(ii)	(iii)	(iv)	(i)	(ii)	(iii)	(iv)
BSUH	35.85	0.041	12	0.114	36.63	0.091	27	0.248
National Average	39.23	0.152	38	0.388	41.36	0.151	37	0.364
Best*	73.65	0.004	1	0.01	82.25	0.011	2	0.02
Worst	25.66	0.614	192	1.73	23.41	0.544	207	1.72

Data Source: <https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-21-march-2018/>

Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons: a panel of consultants reviews this data weekly in order to ensure every incident is appropriately graded. The data is derived from the National Reporting and Learning System for patient safety incidents. Reported patient safety incidents increased by 3.3% in 2017/18 and the Trust will continue to improve its reporting culture and learning from incidents.

Additional note requested by auditors * There is no ‘correct’ or ‘safe’ number of patient safety incidents: a ‘low’ reporting rate should not be interpreted as a ‘safe’ organisation, and may represent under-reporting; a ‘high’ reporting rate should not be interpreted as an ‘unsafe’

organisation, and may represent a culture of greater openness. It is generally regarded as better to have a high rate and for this reason we have assigned the tag of best to the highest reporting rate

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

Mortality

The aim of this work for 2017/18 was the implementation of the National Learning from Deaths Guidance. This included publication of the Trust's policy on learning from deaths, introduction of the Royal College of Physicians Structured Judgement Review (SJR) methodology, sharing learning and reporting to the Public Board. The target was to identify all deaths that were mandated in the guidance and undertake a case note review for these patients.

The Trust appointed the Chief Medical Officer and a Non-Executive Director responsible for overseeing Learning from Deaths.

The Trust published its policy for Learning from Deaths in September 2017; this closely integrates the Medical Examiner Programme and Serious Incident Investigation to ensure all opportunities for learning are identified. 25 staff have been trained in the SJR method for reviewing hospital deaths and to date 48 reviews have been carried out. Quarterly Mortality Reports were submitted to the Trust Board in July 2017 and March 2018. All deaths that are mandated in the guidance have been identified and have either undergone a case note review or are in the process of undergoing a review.

The Deputy Medical Director for Safety and Quality presented to the Grand Round on the subject of learning from deaths including case presentations of 2 avoidable' deaths.

Plan for 2018/19

The focus for the Trust-wide Mortality Review Group in the next 12 months will be the further implementation and embedding of the National Guidance on Learning from Deaths and also to be at the forefront of the national Medical Examiner programme, likely to commence in April 2019.

Four dates have been booked in 2018 to train additional clinicians in the SJR method with further dates are planned. This will provide additional capacity within the organisation to increase the number of deaths that are subject to a SJR. A database is also being developed and rolled out to improve the recording of learning from Structured Judgement Reviews.

Reducing harm from medication (medication reconciliation)

This project has been carried forward to 2018-19 because of unexpected conflicting priorities in pharmacy.

Improving care for the deteriorating patient – Sepsis

Our 2017-2018 Sepsis work has continued to focus on the early recognition and prompt escalation of patients who present to the Emergency Department (ED) or deteriorate on the wards. The sepsis screening tool is now being used in both environments providing a structured guidance to ensure quick diagnosis and rapid administration of treatment (antibiotics and fluids).

Training has been on-going, with more than 1000 staff completing the sepsis screening tool session, which encourages individuals to 'think sepsis' as early as possible using the tool, considering patients at risk and promoting awareness.

The Sepsis Clinical Nurse Specialist is now included in the induction of all new nurses and junior doctors to the Trust, conducts regular study days and has regular sepsis champion meetings to provide up to date information which is then disseminated back to the wards.

There is an E-learning module which is accessible to all staff through our learning system IRIS and promoted through training sessions. The sepsis 6 video <https://vimeo.com/216137460> is also used as a resource, this is a step-by-step guide of the actions staff should take to effectively manage and treat sepsis. This was the 4th most watched video on the NHS Improvement website in 2017.

Sepsis trollies have been introduced to our most acute areas with the highest prevalence of sepsis, providing the staff all the equipment they need to deliver the 'sepsis 6' without distractions, time wasting and offers that important sense of urgency to ensure that treatment is delivered within 1 hour.

Sepsis screening is now a mandatory process within the ED, on their computer system (Symphony) any patient who presents with a National Early Warning Score (NEWS) of 5 or more on arrival to the department will trigger a 'red flag sepsis alert' and the system will prompt the user to get an immediate senior review and early diagnosis.

A Sepsis Clinical Lead for ED has been appointed to support staff and patients alike through education, promotion of early diagnosis with the screening tool and rapid treatment with the sepsis trolley. Simulation training for doctors is being facilitated using sepsis patient cases where improvement in their care was identified, enabling instant hands on learning and improving the safety, effectiveness and efficiency of future care in a safe, learning environment.

This work has helped us achieve 100% for screening patients within the ED and 84% (Q1) 83% (Q2) and 89% (Q3) for administering antibiotics within 1 hour of sepsis diagnosis.

As part of our well established Deteriorating Patient Steering Group (DPSG) we contribute to the Kent, Surrey and Sussex Patient Safety Collaborative Programme (KSS PSC) which builds relationships across the region and identifies local priorities for quality improvements throughout the healthcare setting.

Plan for 2018-19

From June 2018 we will be rolling out the new amended version of the National Early Warning Score (NEWS) 2.0. This scoring system allows early identification of the deteriorating patient by using a simple aggregate in which a score is allocated to the six physiological parameters we measure when monitoring patients. The importance of considering serious sepsis in patients with known or suspected infection, or at risk of infection, is emphasised. A NEWS score of 5 or more is the key trigger threshold for urgent clinical review and action. There is also the addition of 'new confusion' (which includes disorientation, delirium or any new alteration to mentation) to the 'alert, voice, pain, unresponsive' (AVPU) score, which becomes ACVPU (where C represents confusion). This will encourage prompt recognition and escalation of the sepsis patient and part of the clinical response will be to complete a sepsis screening tool and senior doctor review.

Future plans include the development of a blood cultures best practice policy, with accompanying education and awareness to improve time to analyser and reporting to ensure appropriate treatment is commenced as early as possible to provide best possible outcomes for patients.

Introduction of the breakthrough objective 'Deteriorating Patient' as part of the Patient First / True North Improvement Programme; this will maximise the impact of the improvement work and increase compliance with the national standards demonstrated through the CQUIN.

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

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

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

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

Our targets for 2017/18 were to:

- Launch AKI ICE (electronic ordering and diagnostic results information technology system) /PANDA (in-house patient results system) alerting across the Trust.
- Complete the AKI checklist and AKI heart failure guidance and upscale usage.
- Improve measurement and monitoring to inform teaching and training.
- Simulation training for AKI and the deteriorating patient
- Assess feasibility of 24/7 support across the Trust for AKI 2 alerts

During the past 12 months the group leading on this initiative have achieved the following successes:

- Infrastructure for AKI established and tested
- Interface between ICE and PANDA set up
- Infrastructure for reporting AKI WTRs to UK Renal Registry Master Patient Index established
- Access database established to record AKI WTRs and outcomes (in-patient mortality, LOS, critical care admission and level of dependency at discharge)
- Email alerting to renal team of AKI 3 WTRs set up and tested
- Deteriorating patient simulation training commenced

Plan for 2018/19

The plans for next year are focussed around two objectives:

Improving recognition of acute kidney injury by:

- Using Kaizen training for BSUH teams to align testing and access to new AKI resources
- Testing AKI IT changes
- Test capacity to receive & act on AKI 3 results
- Trial of ICE and PANDA AKI infrastructural changes at a ward level
- Continue the AKI audit
- Recruit volunteers for 2nd phase of roll-out

- Refine AKI data visualisation

Improve response after an AKI diagnosis

- Explore overlap with other priorities – NEWs monitoring, sepsis, fluid prescribing,
- Continue evaluation of AKI checklist
- Review AKI social media identity

Patient Experience

Our focus in 2017/18 was to reduce mixed sex accommodation breaches; improve food quality and assistance at mealtimes; provide better information for patients regarding their procedure and operations and improving discharge planning.

Mixed sex accommodation (MSA) remains a challenge due to extreme operational pressure, with bed occupancy in some months being greater than 99%. MSA remains a crucial area of focus and is one of the key operational indicators discussed at each and every site meeting with a clear escalation process in place.

A Food Improvement Group has been established to support the Facilities and Estates Strategy work streams. During 2017/18, and in response to feedback from patients and staff, meal preparation has changed on our wards allowing catering staff to accommodate variants in portion size and accompaniments of the dishes, meaning that patients have greater choice and a reported increased satisfaction.

Following last year's inpatient survey results focus was placed on discharge and developing the discharge process for patients we have seen 76% of the scores for questions in the Leaving Hospital section of the survey in 2017 show improvement or consistency.

In 2016 the Trust scored significantly worse than the Picker average in some questions relating to discharge planning and in the information provided to patients regarding their surgery. Compared with the 2016 inpatient results an 8% improvement was seen in information provided about discharge arrangements and patients' involvement in it. An 8% increase was also seen in patients feeling better informed about their planned surgical procedure.

The views of patients are an important measure in assessing the quality of care provided by staff and are proactively sought via the Friends and Family Test (FFT) National Patient Surveys (NPS) and from Complaints, Patient Advice and Liaison (PALS) contacts, NHS Choices and other social media platforms. In addition, we seek regular and real time feedback from patients and their representatives at the bi-monthly Patient Experience Panel. Engagement meetings with local representative groups such as the Disability Forum, Lesbian, Gay, Bi-sexual and Transgender (LGBT) Health Improvement Partnership, Healthwatch (with more than 1,600 hours of volunteer time being given to BSUH in 2017/18), Speak Out (Learning Disability Advocacy) and the Carer's Centre.

Our Complaints and PALS teams work closely to identify emerging themes from the informal and formal concerns received and in 2017/18 95% of informal concerns were responded to in less than 25 working days. The teams work closely with the specialities to ensure that lessons are quickly learnt from any reported poor patient experience.

Friends and Family Test (FFT) data is collected across all areas of the Trust and, in 2017/18, we greatly improved our score in our Emergency Departments to an average of 89% of patients recommending the service, which was above the national average. We also achieved an above national average response rate of 18% for our Emergency Departments.

Our inpatient response rates remained low in 2017/18 but, since the introduction of an electronic survey in April 2018 a 100% increase has been achieved.

Plan for 2018/19

In addition to the areas detailed above our focus in 2018/19 is to continue to achieve a greater than 22% FFT response rate with a satisfaction score more than 96%.

Key quality improvement areas for the coming year have been identified as: communication with patients and their relatives during inpatient stays; ensuring that patients are able to express concerns during their stay and maintaining their privacy and dignity at all times. In all of these areas we aim to see an improvement in the NPS score, moving the Trust towards the Picker national average.

Reducing hospital acquired infection

Infection Prevention Team is vital in ensuring patient safety, preventing harm, delivering good outcomes, maintaining the Trust's reputation and the public's confidence.

The target for MRSA bacteraemia and *Clostridium difficile* infections are set nationally.

For 2017/18 the Trust trajectory was:

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

The Trust has reported 56 cases of Trust apportioned *Clostridium difficile* infection during the financial year 2017/18. The Trust saw a significant spike in *Clostridium difficile* infection in July 2017 and again in November 2017, with 9 Trust apportioned cases reported. There was a third spike in January 2018, with 7 Trust apportioned cases reported. A root cause analysis (RCA) is undertaken for every Trust acquired *Clostridium difficile* infection, which is then presented at the RCA review group, which the Clinical Commissioning Group (CCG) attend. Although the Trust has breached its target, actions have been implemented across the Trust to enable the Trust to demonstrate a downward trend since February 2018.

The Trust has also experienced four periods of increased incidents (PII) for *Clostridium difficile*. Control measures were implemented, reviewed and monitored throughout the periods of increased incidents so that the spread was minimised to ensure the safety of patients, visitors and staff. Samples were forwarded to the reference laboratory for ribotyping, each case in the PII was a different ribotype, indicating that there was no transmission between the cases.

The Trust has reported one case of Trust apportioned Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infection, in May 2017. A Post Infection Review (PIR) was conducted, which was presented to the RCA review group and CCG. Control measures were implemented, reviewed and monitored. The Trust has shared learning and outcomes through various collaborative forums including the Public Health England Healthcare Association Infection Capture Database, NHS Improvement, CCG, and Clinical Governance. There has been no further Trust apportioned cases reported.

The Trust has reported 32 cases of Trust apportioned Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections. An action plan has been compiled and will be implemented during 2018-19, focusing on venous line insertion and management. There is no external target set for reduction of MSSA blood stream infections.

The Trust has reported 66 cases of Trust apportioned *Escherichia coli* blood stream infections; we are unable to compare this against last year as the Trust reported the whole economy data which was 262 cases.

In April 2017 it become mandatory to report all Trust apportioned *Pseudomonas aeruginosa* blood stream infections, the Trust has reported 10 Trust apportioned cases.

In April 2017 it become mandatory to report all Trust apportioned *Klebsilla spp* blood stream infections, the Trust has reported 14 Trust apportioned cases.

There has been several outbreaks including; *Acinetobacteria*, Carbapenemase producing organisms, *Clostridium difficile*, Measles, Vancomycin resistant Enterococci (VRE) and over 30 outbreaks of diarrhoea and vomiting (causative agents included Norovirus, Astrovirus and Rotavirus). These have had a significant impact on the Trust bed capacity and patient flow.

There have been several incidents which have required the Infection Prevention Team and/or Occupational Health Team to undertake contact tracing, including Tuberculosis, Hepatitis A, Measles and Pertussis. Each patient/staff member exposed was risk assessed by Infection Prevention/Occupational Health, receiving information about the potential contact with an infectious case and any actions to take.

Plan for 2018/19

The 2018-19 targets are:

- Zero avoidable MRSA bacteraemia
- No more than 45 Trust acquired cases of *Clostridium difficile* infection

Best of BSUH

Grade A stroke service

Improvements in our stroke services secured national recognition during the year. Brighton and Sussex University Hospitals were granted Hyper-Acute Stroke Unit (HASU) status last in August and rated Level A by the Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) survey in spring 2018.

We have employed more therapy staff and provide a truly seven-day service for our patients and undertake new procedures in the treatment of stroke. Our Intra Arterial Thrombectomy (IAT) service enables our interventional neuroradiologists and expert team to remove clots through mechanical means.

Working with the teams in the Emergency Department, stroke patients now also get faster treatment and faster admission onto the stroke unit than ever before.

Royal Sussex County Hospital A&E

Changes and improvements in the department have led to massive improvements in patient care and the benefits have been recognised in a swathe of national awards. At the forefront of the Patient First programme, the department has introduced a flexible, annualised self-rostering system for doctors that has had stunning results, including 24 hour a day consultant cover, while a system to book patients into the hospital means patients see a doctor more quickly and this has sped up the time it takes to refer patients on to other departments.

The rostering project won First Place in the Royal College of Emergency Medicine's Quality Improvement Project of the Year Award and was short-listed for a Health Service Journal Award. The 'single clerking' process was shortlisted for a prestigious British Medical Journal award.

Emergency Ambulatory Care Centre opened

The first phase of our £30 million physical improvements to the A&E department was opened by two of Brighton and Hove Albion's top players, Anthony Knockaert and Bruno in March. The new Emergency Ambulatory Care Unit (EACU) at the Royal Sussex County Hospital is one of the first units in the country to combine medical and surgical teams to treat emergency patients who do not need to stay in overnight. This allows patients to move quickly from their initial diagnosis to receiving treatment, which frees up space in A&E and reduces demand on other wards. The Emergency Ambulatory Care unit has 9 treatment rooms, 6 treatment spaces, 3 procedure rooms, 2 side rooms and an IV therapy area that can accommodate 14 patients.

Eastbourne Radiotherapy Centre opened

A new centre run by BSUH opened in July 2017 and provides local cancer patients with state-of-the-art treatment. The £14.5 million centre at Eastbourne District Hospital is an extension of the Brighton-based Sussex Cancer Centre. The Eastbourne centre is equipped with two of the latest linear accelerators (LINACs) which enable patients to receive the best-possible radiotherapy treatment and to receive it closer to home.

The centre's opening means patients can receive all their care in the local hospital, instead of having to travel to Brighton or Maidstone every day for treatment. The new machines provide faster, more precise treatment, which will allow more patients to receive better cancer treatment. The centre is a key part of the strategy to improve radiotherapy services across Sussex and will treat 60-80 patients every day.

[Princess Alexandra visits Royal Alexandra Children's Hospital](#)

In July, Her Royal Highness Princess Alexandra visited the Royal Alexandra Children's Hospital (RACH) to mark the tenth anniversary of the hospital's opening on the Royal Sussex County site. The princess had formally opened the new hospital in 2007 and she has been the children's hospital's Patron since 1954.

The RACH cares for 45,000 children every year from right across the South East and the Care Quality Commission rated it as Outstanding rating last summer; a reflection of the skill, compassion, and exemplary care that all the staff provide for their patients.

During the visit, Her Royal Highness spent time visiting staff, patients, and their families during a tour of the dedicated Children's Emergency Department and the hospital's surgical ward and critical care unit, before being welcomed at a reception hosted by the trust and Rockinghorse, our children's charity.

[World first innovation: the HIV self-testing kit vending machine](#)

Our HIV team, with the Martin Fisher Foundation, installed a hi-tech vending machine that dispenses HIV testing kits in the reception area of the Brighton Sauna in June 2017. This world-first innovation was used over 200 times in the first six months, reaching people who would not normally attend a sexual health clinic and allowing them to test themselves.

Current treatments can reduce the amount of HIV virus in the bloodstream down to undetectable levels, and our HIV team has had a big impact on slowing the rate of transmission of HIV by increasing testing across health care settings in the city, getting people into treatment and using PrEP (pre-exposure prophylaxis).

The HIV team's ambition is to get to zero: zero new infections, zero HIV related deaths and zero HIV stigma. The self-testing machine was shortlisted for a British Medical Journal award for best innovation.

[TAVI: Ten years of pioneering heart surgery in Brighton](#)

December marked the tenth anniversary of Brighton's first TAVI operation, a revolutionary technique that has allowed hundreds of seriously ill patients to have major heart surgery. Instead of cutting into a patient's chest to perform open-heart surgery, surgeons reach the heart by cutting a hole in the groin and inserting a new valve from there.

Surgeons at the Royal Sussex County Hospital have carried out over 800 TAVI operations since their first operation in December 2007.

The procedure can be carried out under local anaesthetic in less than an hour and patients recover more quickly when compared to open-heart surgery, with patients often leaving hospital in less than a week.

Heart valve disease is a common, treatable heart condition but many patients do not suffer severe or visible symptoms, or put the symptoms, which include shortness of breath, fatigue, dizziness and chest pain, down to the natural ageing process. Its prevalence is expected to double in the next three decades.

Statements from partners East Sussex Health Overview and Scrutiny Committee (HOSC) , CCG and HealthWatch

Because of scheduling issues feedbacks from local partners was not possible.

Directors' responsibilities

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

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

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account. The content of this report and our quality improvement priorities were agreed with the Trust's Executive Team, Clinical Directors through our Clinical Management Board and our Board Quality and Risk Committee.

Our priorities follow consultation with our clinical directorates, commissioners, other local providers and patient groups. The report has been reviewed by our commissioners, Local Authority partners and patient groups. By order of the Board



Marianne Griffiths – Chief Executive



Patrick Boyle - Interim Chairman,

Auditors' report

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

This report is produced in accordance with the terms of our engagement letter dated 17 April 2018 for the purpose of reporting to the Directors of Brighton and Sussex University Hospitals NHS Trust (the 'Trust') in connection with the Quality Account for the year ended 31 March 2018 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 17 April 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018 to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our examination, for this report, or for the opinions we have formed.

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

NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections.
- Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and Ernst & Young LLP

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

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15'. These are:

- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, for 2018;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the national patient survey for 2016;
- the latest national staff survey for 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2018;
- the annual governance statement dated 29 May 2018; and
- the Care Quality Commission's quality and risk profiles dated 17 August 2016.

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

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

Assurance work performed

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

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

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

Inherent limitations

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

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

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

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

Basis for qualified conclusion

The Trust has not received feedback on the Quality Account from NHS Brighton and Hove CCG, Healthwatch Brighton & Hove or East Sussex Health Overview and Scrutiny Committee. We have therefore not been able to consider whether information contained in the Quality Account is materially inconsistent with the following other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15':

- feedback from all Commissioners;
- feedback from Local Healthwatch; and
- feedback from all other named stakeholders involved in the sign off of the Quality Account.

Qualified Conclusion

Except for the possible effects of the matter described in the Basis for Qualified conclusion section of our report, based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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

*Suresh Patel, Associate Partner
For and on behalf of Ernst & Young LLP
Southampton
21 June 2018*

Notes:

1. *The maintenance and integrity of the Brighton and Sussex University Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.*
2. *Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.*

Glossary of terms and acronyms

Caldicott The Caldicott review and data protection legislation enforce strict legal guidelines to the storage, maintenance and access to patient information. The Freedom of Information Act 2000 and the Information Governance initiative both support the need to maintain the principles of effective confidential data control. A Caldicott Guardian is a senior member of staff appointed to protect patient information.

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

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

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

Clinical Commissioning Groups (CCGs) Clinical Commissioning Groups replaced primary care trusts in April 2013; they are responsible for planning and designing local health services in England. They do this by 'commissioning' or buying health and care services.

A team of clinical advisors based within the Emergency Operations Centres providing support for patients with non-life threatening conditions.

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

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.

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

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

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

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

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

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

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

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

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

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

MRI Magnetic Resonance Imaging.

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

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

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

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

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

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

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.

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.

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

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

Appendix 1: National Clinical Audits and National Confidential Enquiries listed 17/18

National Audits listed in 17/18

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
BAUS Urology Audits: Cystectomy	Yes	Yes	100%	Awaiting latest results. There are no expected recommendations
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	100%	Awaiting latest results. There are no expected recommendations
BAUS Urology Audits: Stress Urinary Incontinence Audit	Yes	Yes	100%	Awaiting latest results. There are no expected recommendations
British Association of Urological Surgeons (BAUS) Urology Audits: Nephrectomy	Yes	Yes	100%	Awaiting latest results. There are no expected recommendations
Cardiac Rhythm Management (CRM)	Yes	Yes		Data unavailable
Case Mix Programme (CMP) ICNARC	Yes	Yes	100%	Quarterly benchmarking reports are circulated and reviewed regularly amongst the critical care directorate. The Clinical Lead presents the data at Quality Safety & Patient experience (QPSE) meetings. ICNARC shares data with the Department of Health in their Specialised Services Quarterly Dashboard & with Healthcare Quality Improvement Partnership (HQIP). Data from the ICNARC report is also shared with the South East Coast Critical Care Network who in turn present and discuss at their quarterly forums.
Congenital Heart Disease (CHD)	Yes	Yes	100%	All eligible cases are uploaded to the National Institute for Cardiovascular Outcomes Research (NICOR) database and a sample is audited by a dedicated team at NICOR to validate the data.

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
Coronary angioplasty (PCI)	Yes	Yes	99%	All patients undergoing PCI are entered onto a dedicated database following their procedure. The Consultant operator activity and outcome data are published online and these data are available for public review.
Diabetes (Adult) ND(A)	Yes	Yes	56%	Collation and submission of all data required for the national audit continues to be difficult and we share similar issues with other secondary care institutions. However we are exploring and internal solution with our IT department and the problem is also being addressed via the Sustainability and Transformation Partnership diabetes oversight group.
Diabetes (Adult): National Diabetes Footcare Audit	Yes	Yes	21%	Our participation rate has been disappointing. However, we have taken part in a recent Sustainability and Transformation Partnership programme which has increased participation in the Diabetes Footcare Audit as part of its aims.
Diabetes (Adult): National Diabetes Inpatient Audit	Yes	Yes	100%	We scored poorly in the assessment of patients' feet. We are undertaking a quality improvement project to address this.
Diabetes (Adult): National Pregnancy in Diabetes Audit	Yes	Yes	100% (RSCH)	There is no data release for this year. However, the team continues to submit and review care on an ongoing basis.
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	The 2016-17 report is not yet published at time of writing, but preview results have been circulated for internal use. Our unit's performance in 2016-17 is comparable to the national average for many of the parameters measured. However, compared to our previous performance in 2015-16, we have not performed so well. The main reason for under performance is a nearly 25% increase in patient numbers (from previous 160 to current over 200) with no matching investment in resources. Hence clinic capacity and other areas have suffered, leading to a fall in several parameters measured. A business case for additional resource has been submitted in Nov 2017 and a decision is awaited.

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
Endocrine and Thyroid National Audit (British Association of Endocrine and Thyroid Surgeons)	Yes	Yes	100%	Consultant-level data is available online and is reviewed regularly.
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls	Yes	Yes	100%	An action plan is in development.
Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database	Yes	Yes	83.2%	The database continues to show excellent results for BSUH; Surgery takes place on the day of, or day after admission with a fracture neck of femur for 83.1% of patients (compared with national average of 70.6%); Average length of stay is 16.4 days compared with a national average of 21.6 days.
Head and Neck Cancer (HANA)	Yes	Yes	100%	National audit results are reviewed at Tumour Group meetings and a number of more focussed local audits are also undertaken during the year.
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	100%	All patients that are newly commenced / established on biologics are now added to audit at each visit to our infusion suite. The IBD pharmacists regularly see new starters in their outpatient clinics to counsel them on the drugs which help to empower patients to make an individual choice on therapy. We also run regular virtual clinics to assess and approve ongoing treatment for our patients.
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%	Awaiting feedback from LeDer Programme
Lung cancer (NLCA)	Yes	Yes	100%	National audit results are reviewed at Tumour Group meetings and a number of more focussed local audits are also undertaken during the year.

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	92-100%	We continue to develop and work on a number of projects including: creating partnerships within the major trauma network to facilitate the appropriate early transfer of patients both in and out of the Major Trauma Centre (MTC); establishing network pathways to strengthen care processes; improving the infrastructure of the MTC and allowing further development of care pathways. We also have an additional member of staff on the Trauma Team helping with the collection and submission TARN data.
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	100%	BSUH are the 6th rated level 3 unit with surgery in the country. Work is on-going to understand why the CCG level data is higher than the Trust data as this suggests that the deaths are occurring outside of BSUH.
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%	The call-to-balloon and door-to-balloon times are reviewed for every individual case to ensure that the National targets are being achieved. Specific delays to treatment are discussed and investigated where appropriate.
National Adult Cardiac Surgery Audit (ACS)	Yes	Yes	100%	Outcomes data are presented regularly within the Cardiac Surgery Clinical Governance and Management meetings, and the department maintains a record of all deaths following cardiac surgery, which are reviewed and action points documented.
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	100%	In our Breast Unit, elderly patients are holistically assessed in a combined clinic run by Dean of the Medical School, Breast Surgeon and Consultant in Geriatric Medicine. Patients are also referred for a consultant led anaesthetic assessment prior to surgery to ensure the safety of any proposed procedure. Individual cases are discussed at a Multi-Disciplinary Meeting (MDM) and discussion making is a shared process respecting ultimately the patient's wishes/decision. We are exploring and trying to develop surgical intervention under regional blocks if general anaesthesia is considered too risky.

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
National Audit of Dementia: Delirium Spotlight Audit	Yes	Yes	100%	In conjunction with colleagues in ED a project is being undertaken to encourage doctors to complete a delirium assessment on first clerking. Policies around management of delirium and sedation have also been reviewed. To improve communication with carers of patients with dementia, a carer's booklet has been developed and is being rolled out.
National Bowel Cancer Audit (NBOCAP)	Yes	Yes	100%	The audit report indicated that the Trust was an outlier in 90 day mortality after elective major bowel cancer surgery. However, the Trust launched a detailed investigation of the data and found that deficiencies in local audit and data processing resources were the cause; a number of emergency patients had been wrongly categorised as elective and therefore the data submitted was inaccurate. Following correction of the data, there is no concern over the mortality rate as this within normal limits. However, it has not been possible to make corrections to the published report. The team has however, taken steps to ensure that future data submissions are accurate and robust.
National Cardiac Arrest Audit (NCAA)	Yes	No	not applicable	
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)	Yes	Yes	Approx. 45%	Through the Enhancing Quality programme, audit data are submitted monthly to the Kent Surrey and Sussex Academic Health Science Network and are reviewed regularly and compared with other Trusts in the region. The trust faces challenges in collecting all the data required across two hospital sites and this will be addressed in the coming year. Reports were published recently and are being reviewed by the clinical team.
National Comparative Audit of Blood Transfusion programme:	Yes	No	not applicable	A lack of available staff time has prevented participation.

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
National Emergency Laparotomy Audit (NELA)	Yes	Yes	>85%	The latest published report (up to Nov 2016) shows that case ascertainment has been lower than desired (50-79%), therefore considerable effort has been applied over the last year to improve on this, and the latest progress report indicates that the Trust is now submitting data on over 90% of eligible patients.
National Heart Failure Audit (NHFA)	Yes	Yes	100%	Steps taken to improve the proportion of patients having a prompt specialist review at the PRH include: the appointment of a new heart failure Consultant who works at PRH 1 day per week; a Specialist Nurse who is based full-time solely at PRH, and from 2018 there is a locum consultant cardiologist working across both Trust sites, working at the 'front door' with the Emergency Department teams.
National Joint Registry (NJR)	Yes	Yes	>90%	The Trust continues to actively participate in the National Joint Registry and data shows continued improvement.
National Maternity and Perinatal Audit	Yes	Yes	100%	The audit showed that one of our sites had a higher than expected rate of the 3rd and 4th degree perineal tears. Steps taken to address this concern therefore include: development of a local protocol in line with national guidance for pelvic floor protection; establishment of a perineal care workshop led by our urogynaecologists and educational team; inclusion of perineal care in labour as part of the mandatory annual skills drills, and encouraging all women to access some online learning resources including guidance on perineal massage.
National Neurosurgery Audit Programme	Yes	Yes	100%	The unit level data is used for National peer review. Last year's audit showed no individual or unit outliers in patient outcomes.
National Ophthalmology Audit	Yes	No	not applicable	Technical problems in securing the relevant software have meant that the Ophthalmology department has not participated to date. However, the team hopes to be in a position to do so for the last year of the audit.

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Yes	Yes	95-99%	The Trust's outcomes are reviewed regularly.
Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	Yes	Yes	100%	Work continues to improve admission temperatures. Maternity theatres are now kept at 23 degrees Celsius at all times. All standards including admission temperature are at or above the UK mean.
Oesophago-gastric cancer (NAOGC)	Yes	Yes	61-70%	Case ascertainment is lower than we would like due to the team continuing to experience extreme difficulties in uploading the required data to the audit. This has been a frustration for some years as it means that interpretation of the results has its limitations. However, the team are hopeful that a solution may have been found to the upload problem but unfortunately that is probably not going to help with the data already published over the past few years.
Patient Reported Outcome Measures (PROMS): Hip replacement, Knee replacement, Hernia repair, Varicose Veins	Yes	Yes	78%	This case ascertainment figure includes all 4 pathways, however collection of patient reported outcomes data for groin hernia and varicose vein surgery have now been discontinued. Future reports will therefore include only hip replacement and knee replacement outcomes, where the case ascertainment figure is 88%. Knee replacement outcomes continue to be lower than expected according to the nationally-applied formula. Review of the data indicates that the PROMS tool is not sensitive enough to adequately account for the patient casemix at the complex end of the spectrum of hip and knee replacement patients that are treated at BSUH. Nevertheless, further detailed reviews of the data are being undertaken at present.
RCEM Pain in Children	Yes	Yes	100%	Report not yet available; this is scheduled for publication in late May 2018

National Clinical Audit	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted	Action taken or planned
RCEM Procedural Sedation in Adults	Yes	Yes	100%	Report not yet available; this is scheduled for publication in late May 2018
Royal College of Emergency Medicine (RCEM) Fractured Neck of Femur	Yes	Yes	100%	Report not yet available; this is scheduled for publication in late May 2018
Sentinel Stroke National Audit Programme (SSNAP): SSNAP Clinical Audit / Post Acute Organisational Audit	Yes	Yes	>90%	The Stroke Unit became a Hyper Acute Stroke Unit in Sept 2017 and patients now have access to 7-day therapy input which means more patients should reach their therapy goals which is an area we have struggled with in the past. Also, from April 2018 our patients will have access to a clinical psychologist. It is very rare for stroke units to have psychology input and it will be a major boost for all our patients. Working with bed managers and site teams, we also aim to improve on bed management to enable a faster admission to the stroke unit for eligible patients.
Serious Hazards of Transfusion (SHOT): UK national haemovigilance scheme	Yes	Yes	100%	All cases are reviewed at the Patient Blood Management Committee that meets 3-4 times per year.
Specialist rehabilitation for patients with complex needs following major surgery	Yes	No	N/A	The Trust has been unable to participate as the post of Consultant in Rehabilitation Medicine has been vacant during the audit period.
UK Parkinson's Audit	Yes	Yes	100%	Local reports were published in March and therefore action planning is ongoing. Some actions already identified include adding specific enquiries to the annual review documentation to ensure important aspects of patients' condition, experience and information needs are discussed at least annually.

National Confidential Enquiries listed in 17/18

National Confidential Enquiries	Was the Trust eligible to take part	Did the Trust take part	Percentage of cases submitted
Acute Heart Failure	Yes	Yes	100%
Cancer in Children, Teens and Young Adults	Yes	Yes	100%
Chronic Neurodisability	Yes	Yes	89%
Perioperative Diabetes	Yes	Yes	Study still open
Young People's Mental Health	Yes	Yes	100%

Appendix 2: Actions resulting from reviews of a sample of local clinical audits in 17/18

Specialty	Project Title	Actions to improve the quality of care
Acute Medicine	Alcohol Detox audit	The audit showed that Day1 detox was being started more accurately and auxiliary medications were more regularly prescribed. Areas for improvement were noted as documentation of alcohol use in the clerking and confusion over the initial stat doses of medications. The Detox documentation will be revised to better emphasize the stat doses.
Anaesthetics	Ventilator acquired pneumonia	Adoption of Selective Decontamination of Digestive Tract Protocol to prevent serious infections and reduce mortality in critically ill patients. Routine use of antibiotics for out-of-hospital cardiac arrests.
Anaesthetics & Acute Pain	The Use of Gabapentin in managing pain following laparoscopic nephrectomy	Reducing length of stay and opioid sparing because of a lowering of pain scores
Anaesthetics & Acute Pain	Increasing the remit of the Acute Pain Team	Increasing our remit to include patients who have non-surgical pain; pain resulting from poly-trauma and trying to reduce admissions by reviewing those with chronic pain flare ups in the ED by working more closely with the chronic pain team. The benefits to patients are a reduction in the length of stay; prevention of unnecessary admissions and facilitation of faster discharges.
Cardiology	What's the bleeding point?	This audit identified a financial cost of £35k resulting from unnecessary clotting studies. The recommendations include the introduction of a blood test champion on the ward, a ward round proforma & better education on costs of blood tests and indications.
Dermatology	An audit of the suspected melanoma pathway in BSUH	Timely referral to a dermatologist is essential for quick and accurate diagnosis of melanoma. 96% of patients referred under the 2 week rule, were seen within two weeks. Of those that were not seen within two weeks, there were clear patient related reasons such as one patient had broken her hip so her appointment was delayed, and one patient cancelled his initial appointment as he was away on holiday.

Specialty	Project Title	Actions to improve the quality of care
Diabetes & Endocrinology	'Touch the Toes' Foot care project	The project aims to improve the care of in-patients with diabetes. It involves a quick assessment to look at the feet of everyone admitted with diabetes. We are introducing a simple assessment tool and training foot care champions in key ward areas to assess and improve the foot care in the 20% of in-patients with diabetes. The only way to improve care is to look at and assess the feet of all patients with diabetes..
Diabetes & Endocrinology	Perioperative care	People with diabetes going for surgery have a greater likelihood of cancelled surgery, a longer length of stay, more wound infections and wound healing problems than those without diabetes. We are improving the pathway of people with diabetes having surgery. This involves identification when listed for surgery; pre-operative optimisation of glycaemia, appropriate peri-operative management of diabetes and tight control of glucose post-operatively.
Elderly medicine	Service Improvement and Innovation / Specialty Service Redesign	Implementation of a patient centred redesign of frailty services via a Frailty Strategy. This successful work stream has been recognised at National Level with the Team being shortlisted for a Health Service Journal (HSJ) Award in Specialty Service Redesign. Locally, the team won a KSS Award for 'Leading for Service Improvement and Innovation' in 2017.
Elderly Medicine	Emerald falls project	By focusing on behaviours and practical approaches to reducing falls in patients with dementia we have seen a reduction in falls of 57% in 2017/18.
Emergency Department	Paracetamol Overdose Audit	The department showed an improvement in achieving the treatment standards when compared with the most recent Royal College of Emergency Medicine audit in 2013. Planned improvements include clarification of treatment plan for patients who lack capacity and the introduction of an easier to navigate proforma.
HIV/GUM	Management of Sexual Assault at the Claude Nicol Clinic Re-Audit	The re-audit found; significant statistical improvements from previous audits; improved communication between services and referral pathways and improved pathways for patients with increased support options.
Neonatology	National HIV and Syphilis Surveillance	BSUH are the top antenatal screening centre in the UK

Specialty	Project Title	Actions to improve the quality of care
Neurology	Outcomes of Type A Botulinum Toxin - 'Botox®' treatment in the prevention of chronic migraine headaches in adult patients within BSUH.	100% of patients met the qualifying criteria for Botox®. 17% were deemed non-responders but continued to obtain benefit if severity is taken into account. BSUH are in discussions with local CCG regarding deviating from the NICE guidance to be more inclusive.
Neurology	First seizure Re-audit	The audit showed that significantly more CT head scans were performed compared to the 2012 audit, however documentation of driving status and neurological examination had declined. These areas will be addressed via regular teaching sessions, poster and Trust guidelines for patients presenting with suspected seizure.
Nutrition & Dietetics - adults	Irritable Bowel Syndrome (IBS) outpatient service evaluation	Abstract published March 2018 Journal of Human Nutrition and Dietetics. New IBS service very well-received by patients and has significantly reduced waiting times and Did Not Attend (DNA) appointment rates saving £11.6K annually
Nutrition & Dietetics - paediatrics	Measured energy expenditure of non-ambulant, artificial fed, neurologically impaired patients: How predictive is the Oxford equation?	Abstract completed submitted and oral presentation given at 2017 European Society for Paediatric Gastroenterology Hepatology and Nutrition conference. Continued clinical use of validated test to better identify and meet this groups' nutritional requirements
Paediatric Surgery	Audit of Paediatric Consent	It was noted that Consent forms are generally well completed, however there is room for improvement in a couple of the fields. The learning was shared at the local clinical governance meeting and the team will be introducing stickers into the notes to improve compliance.
Pharmacy	Antibiotic Point Prevalence BSUH 2015/16/17/18	Month on month improvement in review of antibiotic prescriptions achieved by increased focus on anti-microbial stewardship and reporting results monthly to each directorate.
Respiratory Medicine	Chest Drain Audit	Recommendation to introduce a standardised chest drain proforma to improve documentation and adherence to guidelines for chest drain insertion.