

Brighton and Sussex **NHS**
University Hospitals
NHS Trust



Quality Account 2015-16

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Part 1

Part 1

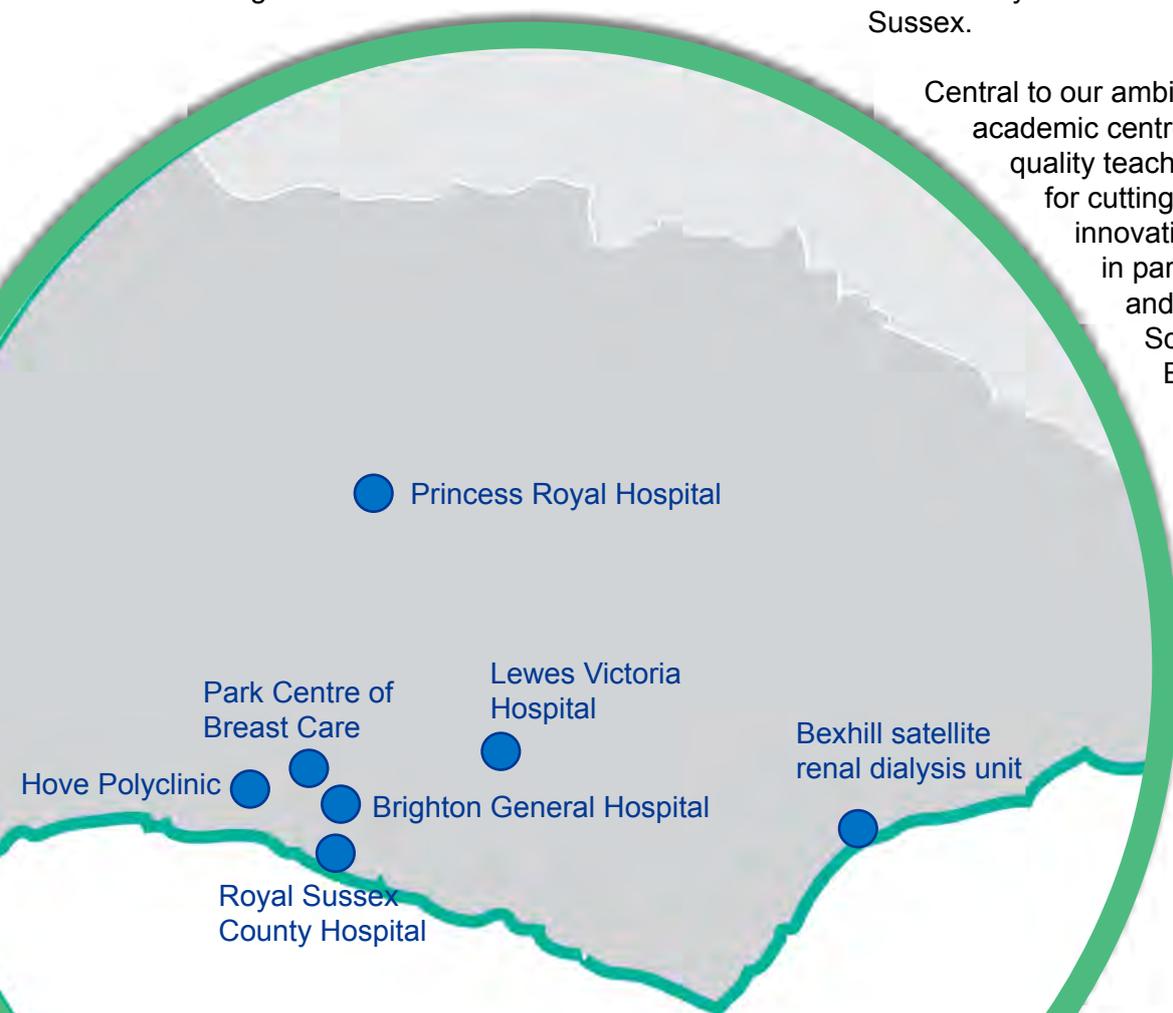
What we do

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital working across two main sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital and is also the Major Trauma Centre for the region. We provide District General Hospital services to our local populations in and around Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients from across Sussex and the south east of England.

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

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

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



Ten Facts about the Trust

In 2015-16 the Trust:

1. Employed **8,200** members of staff
2. Received the help of **430** hospital volunteers
3. Delivered **5,900** babies
4. Saw **161,000** A&E patient attendances
5. Treated **53,000** patients for unplanned procedures and 15,000 for planned procedures
6. Treated **44,000** patients as day cases
7. Cared for patients in **790** acute beds
8. Received **455** compliments and plaudits from patients and relatives
9. Had **2,500,000** hits on the public website and **2,500** Twitter followers
10. Received approval for **£484.7 million** hospital redevelopment funding



Purpose of the Quality Account

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



Part 1

Statement on quality from the Chief Executive

Welcome to the Annual Quality Account which reviews our performance on safety and quality in 2015/16 and sets out our safety and quality priorities for 2016/17. Mr Matthew Kershaw was the Chief Executive and Accountable Officer up until 31 December 2015, Ms Amanda Fadero was Interim Chief Executive and Accountable Officer from 1 January 2016 to 31 March 2016, and Dr Gillian Fairfield became Chief Executive and Accountable Officer on 1 April 2016.

Part 2 of this account details the progress we made in the delivery of our quality strategy in 2015/16 against a range of safety and quality indicators; and the progress we made against the specific priorities we set ourselves for 2015/16. Our three priorities in 2015/16 were: Improving the care of deteriorating patients with sepsis; Improving the care of deteriorating patients with acute kidney injury; Implementing the Right Care, Right Place, Each Time programme. We made progress with each of these areas of work and these priorities were partially achieved but we have further work to do and have set ourselves additional targets for 2016/17.

Overall, 2015/16 was a very challenging year for the Trust, particularly in ensuring that patients who arrive at our hospitals in an emergency are treated, admitted or discharged safely and quickly. Our performance against the four-hour Accident and Emergency standard remained below the required level of 95% of patients treated within four hours throughout the year. This was reflected in the findings of a Care Quality Commission (CQC) inspection which took place in June 2015. The CQC found that poor patient flow was having an adverse impact on care and patient experience in the Emergency Department (ED) at the Royal Sussex County Hospital and rated the Trust as 'inadequate' both for safety and well-led when its report was published in September

2015. We also failed to meet the waiting times standards and treat patients in a timely way and many of our patients and staff experienced problems with the Central Booking Hub, which we are now addressing.

The CQC carried out a comprehensive follow-up inspection in April 2016. While we are still waiting for the formal report following this inspection, CQC has made it clear that we have not yet made sufficient progress in addressing the concerns raised in previous inspections and has required us to make significant improvements quickly in patient safety, privacy and dignity, the timeliness with which we treat patients and the effectiveness of the Board. CQC has formally served the Trust with a Section 29a Warning Notice (Health and Social Care Act 2008) requiring these improvements. To address this and improve the quality and safety of our services, we will: implement a new and systematic approach to quality and service improvement; establish a new Programme Management Office to ensure delivery of our key programmes, including our CQC improvement plan; appoint a new Director of Clinical Governance; review and strengthen our central clinical governance team; and implement revised Board, committee and executive governance arrangements.

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



Dr Gillian Fairfield
Chief Executive



Our approach to quality

The Trust's approach to quality is centred on our patients, through a number of questions about patient safety and patient experience outlined below.

The vision of the strategy is to move to a person-centred view of safety and quality with a particular focus on kindness and compassion as the driver for the delivery of the high quality services desired by the population we serve.

How can I be sure that the care I receive will not harm me?

In order to minimise the risk of harm, the care patients receive should:

- be delivered by people that are proactive about recognising error and risk
- come from people that are capable of learning from mistakes made by themselves as well as other healthcare professionals

How can I be sure that I will be involved in making decisions that affect me?

In order to ensure patients are fully involved in their care it should:

- place the patient at the centre of any decisions
- be delivered by staff who recognise and value the patient as an individual
- ensure that communication with the patient is clear, effective and timely



How can I be sure that I will receive the best possible care?

In order to provide patients with the best possible care it should:

- be delivered according to the best current evidence
- be measured against appropriate outcomes for the patient
- be delivered in accordance with relevant national targets with regard to waiting times
- be delivered by the most appropriate, best trained people in adequate numbers

Part 1

How can I be sure that feedback on experiences will be acted upon?

In order to ensure that feedback on the care of patients is used effectively we will:

- actively seek feedback on the care that we provide
- strive to adjust care in the light of the feedback received
- act promptly to address concerns when patients raise them
- be open and honest about the reasons if the care falls below the standard expected

How can I be sure that I will be treated fairly, as an individual and part of my community?

In order to ensure patients are treated fairly and do not suffer discrimination we will ensure that:

- the services we deliver reflect the problems faced by patients and their community
- information is provided in a form that patients can understand
- patients are able to access and navigate our buildings and premises

How can I be sure that I will be treated with kindness and compassion?

In order to ensure kindness and compassion the care patients receive should:

- be delivered by a group of individuals who share a common set of values and behaviours with kindness and compassion at their core
- actively seek the needs, wishes and fears of the patient as well as those of the patient's family and carers
- be individual to you and make you feel valued





Part 2

Part 2

Priorities for improvement

We developed some initial ideas about our priorities for 2016-17 in discussion with our partners in January 2016. However, following the inspection from the Care Quality Commission (CQC) in April 2016, the feedback we have received from the CQC and the areas identified for improvement in the Section 29A Warning Notice served on the Trust in June, our absolute focus this year will be the delivery of our CQC improvement plan.

Progress with our improvement plan will be monitored by the Board, Quality and Performance Committee and Board of Directors on a monthly basis. We will share progress with NHS Improvement, commissioners and patient groups on a regular basis. We will use the resources of our new Programme Management Office to ensure that we deliver our actions in accordance with our required timescales.



Review of quality performance

This section of the report describes the progress we have made on the priorities we agreed last year.

Reducing avoidable falls

Inpatient falls in hospital are a significant problem throughout healthcare and a significant source of increased length of stay, excess morbidity and avoidable mortality every year within the Trust. When this project was initiated in 2009 over 1,500 clinical incident reports per annum were submitted detailing patient falls. Over 200,000 falls are reported to the National Reporting and Learning System annually making it a significant problem, not only locally, but on a national level. Although not all falls can be prevented we have learnt that a significant number can be avoided.

Targets set for financial year (April 2015/March 2016): **Partially Achieved**

A 7% falls reduction target was set for 2015-16. Although the falls rate came down for the sixth consecutive year the rate of reduction was only 2%. The rate for the year was 3.36 falls per 1000 bed stay days compared to 3.42 in the previous year.

During the year the Trust achieved its lowest ever monthly falls rate of 2.74 falls per 1000 bed stay days in July. However, the target was missed because of two difficult months, October and December, when 90 and 92 patients fell during the month. During 2015 the Royal College of Physicians published the National Audit of Inpatient Falls.

The audit identified the average falls rate in England and Wales as 6.63 falls per 1000 bed stay days. Based on the average national rate we could have expected to have 1732 falls, during the year 877 were reported, some 856 fewer than the average rate. All but one ward has a lower rate than the national average.

Improvements delivered in financial year (April 2015/March 2016): We have shared the falls methodology through various collaborative forums including the 2015 Participatory Innovation Conference. In collaboration with the University of Southern Denmark and Hertfordshire Business School the team submitted a bid to the Health Foundation Programme Scaling Up for Improvement. We are one of four Acute Trusts selected to work with the Kent Surrey Sussex Patient Safety Collaborative on their improving culture, capability and leadership programme. The approach adopted for the falls programme is also being utilised in this initiative.

Future goals for next financial year (2016/2017): Although the falls rate continues to drop, the improvements in the past two years have been small. We continue to see an opportunity to reduce the rate further but it is unlikely the reduction will be substantial and therefore we have set a challenging target of a further 5% reduction bringing the falls rate down to 3.19 falls per 1000 bed stay days.

Part 2

Mortality

Mortality is a key indicator of the safety and quality of all the services provided by a hospital.

Targets set for financial year (April 2015/March 2016): **Achieved**



The initiative will now be taken forward and monitored by the Trusts mortality review group.

Improvements delivered in financial year (April 2015/March 2016): This year the Trust Mortality Review Group (TMRG) has been re-established and now meets monthly. This multi-disciplinary group reviews mortality rates, mortality alerts and is developing the Trust's strategy for detailed mortality reviews. An increase in the Standardised Hospital Mortality Index, though still below the national average, was identified and a detailed mortality review carried out as a result. Although no clear cause for the increase was identified, a number of potential improvements have been fed back to departments as a result of this review. Detailed consultant-led case note reviews have also been carried out in relation to the deaths of patients with learning disabilities and patients requiring Non Invasive Ventilation.

Future goals for next financial year (2016/2017):

- To strengthen the links between the TMRG and departments by representation from Departmental Mortality Leads at each TMRG.
- To expand the Medical Examiner (MEs) programme to include Princess Royal Hospital.
- To use the MEs as a first stage mortality review and increase the number of departmental mortality reviews triggered by an ME referral.
- To develop a Trust-wide database using a standard template for recording mortality review.
- To pilot and develop a feedback questionnaire for bereaved relatives on the quality of care they and their relative received.

Enhanced recovery

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



Targets set for financial year (April 2015/March 2016): **Partially Achieved**

Our aim was to continue to introduce the Enhanced Recovery Programme into other areas of surgery to improve patient outcomes and experience. We also aimed to meet the 2015/16 improvement targets set by the Kent Surrey Sussex Allied Health Science Network (KSS AHSN) regional team and engage in collaborative events to share best practice.

Improvements delivered in financial year (April 2015/March 2016): The three original ERP pathways (colorectal, gynaecology and orthopaedics) are now fully established and seen as business as usual within the Trust. The improvement period for 2015/16 was set from September 2015 to March 2016 discharges, the cumulative data so far (September 2015 – Jan 2016) shows:

- For colorectal we have a cumulative Appropriate Care Score (ACS) of 90.67% with the improvement target set as between 86.82 – 90.00%.
- For gynaecology we have a cumulative ACS of 94.71% with the improvement target being 90%.
- For orthopaedics we have a cumulative ACS of 80.79% with the improvement target being set between 84.13 - 88.39%.

With ACS being the percentage of patients who received all the measures of care. Whilst not quite hitting the achievement target, as yet, in orthopaedics we feel fully cited on the issues with early mobilisation being the main area for further improvement. Ongoing work is being undertaken to improve our performance on this measure which will in turn increase our overall ACS.



The year has also seen the launch of three further pathways in obstetrics, emergency laparotomy and fractured neck of femur. Data collection for these pathways is in the early stages. We are also in the process of launching pathways internally in upper GI and elective gynaecology.

All our ERP pathways have seen an improvement since the start of the programme, particularly for orthopaedics. Colorectal has shown considerable improvement and has trended above the regional average since May 2014. We were very proud to win the 'EQR team of the year' award at the KSS AHSN Expo and Awards 2016. This was an award shared by all our EQR teams across the Trust.

Future goals for next financial year (2016/2017): To continue to develop Enhanced Recovery into other areas of surgery and to achieve the 2016/17 improvement targets set by the KSS AHSN regional team.

Part 2



Reducing harm from medication (medication reconciliation)

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

Targets set for financial year (April 2015/March 2016): **Partially Achieved**

Our aim was to keep the target of 90% for all patients to have a medicines reconciliation within 24 hours of admission as a Trust priority for 2015/16. Pharmacy has maintained a monthly average medication reconciliation rate in excess of 70% within 24 hours of admission in the last 12 months, with the overall rate being 78%. There are now more wards regularly achieving the target of 90% than in the previous year.

Improvements delivered in financial year (April 2015/March 2016): More wards are regularly achieving the 90% target but the overall rate is still below the required 90%, sitting at 78%. This is still in excess of the 70% cited in the original NICE guidance.

Future goals for next financial year (2016/2017): To increase the number of wards achieving the 90% target and ensuring that the overall Trust target is met.



Enhancing quality

Enhancing Quality (EQ) is a clinician-led quality improvement programme launched in January 2010 across Kent, Surrey and Sussex encompassing 10 acute Trusts, six community providers and three mental health Trusts. Enhancing Quality aims to improve patient outcomes and reduce variation in care.

Targets set for financial year (April 2015/March 2016): **Partially Achieved**

Our aim has been to continue to take part in collaborative learning events and the sharing of best practice within Kent Surrey and Sussex Allied Health Science Network (KSS AHSN), to continue to develop our heart failure service and deliver the improvements required to meet the targets set for community acquired pneumonia.

Part 2

Improvements delivered in financial year (April 2015/March 2016): We participated in three Enhancing Quality projects - heart failure, community acquired pneumonia and the more recently introduced chronic obstructive pulmonary disease (COPD) discharge programme. We were very proud to win the 'EQR team of the year' award at the KSS AHSN Expo and Awards 2016. This was an award shared by all our EQR teams across the Trust.

Future goals for next financial year (2016/2017): Continue to take part in collaborative learning events and the sharing of best practice within Kent, Surrey and Sussex. Continue to develop our heart failure service and to deliver the improvements required to meet the targets set for the community acquired pneumonia and COPD pathways.



Improving care of frailty patients

The care of frail, usually older people is a core part of the Trust's Clinical Strategy. Recent national reports have all been critical of the care delivered to frail and elderly patients and there is increasing evidence that a move towards shifting services closer to the front door of the hospital and outward facing into the community provides better outcomes. This initiative is aimed at developing a whole system approach to the care of frail patients.

Targets set for financial year (April 2015/March 2016): **Achieved**



We plan to continue the development of the service and we are currently working on the paperwork to support frailty care which will further streamline and support all elements of the patient's care. In addition the care will provide a robust source of data for identification and measurement.

Several multidisciplinary teams have been established in order to support the delivery of this project, including the Hospital Rapid Discharge Team (HRDT).

Improvements delivered in financial year (April 2015/March 2016): During 2015/16 we have continued to develop the pathway for the identification and management of frail patients, from the front door to the ward. This has been supported by a number of initiatives, including:

- The implementation of a 'discharge to assess' programme on the Care of the Elderly wards with the aim of returning patients to their own homes when they are medically ready and reduce delays to discharge.
- Increasing the role of the voluntary sector to help frail patients when they are discharged home from hospital
- Implementing a Consultant delivered Frailty Liaison service to improve care for frail patients not admitted directly to the Care of the Elderly service
- Increase the number of patients being seen in our rapid access outpatient service (RACOP) to help admission avoidance and reduce length of stay for frail patients.

Future goals for next financial year

(2016/2017): Our plan is to consolidate this year's achievements and embed the changes. It is currently anticipated that the Frailty pathway will be re-visited as part of the 17/18 Commission for Quality and Innovation (CQUIN) programme as part of the Integration work stream.

Improving care for the deteriorating patient - Sepsis

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



Improving the care of frailty patients

Dr Tej Richardson has pioneered the model for Frailty at Princess Royal Hospital. In close association with the Senior Nurse for the Day Hospital, inpatients with frailty needs are picked up at the daily bed meeting and through the HRDT team leading to a comprehensive geriatric assessment. In parallel to this a Rapid Access clinic is operational aimed at admission avoidance in the frail older patient. With new consultant appointments anticipated the service will roll out to operate all five weekdays.

Our aim was to improve the early identification and treatment of patients who are at risk of sepsis on arrival to the hospital by developing a process to: Screen for risk of sepsis; Perform tests to confirm diagnosis; Initiate intravenous antibiotics within one hour.

Targets set for financial year (April 2015/March 2016): **Partially Achieved**

Part 2

Improvements delivered in financial year (April 2015/March 2016): A working group has been established and a sepsis protocol and screening tool has been agreed and rolled out from October 2015 across all sites.

We have updated and published a new version of the screening tool with the recommendations made by staff on the front line. The warning prompts on our A&E system are working effectively and we are now seeing real improvements in the recording of the outcome of the screen on the electronic system. Training and education has continued across the wards, aimed at junior doctors, consultants, nursing staff and administration staff.

Sepsis champions are being identified and roles and responsibilities defined.

Despite a late start to the project the team have exceeded expectations for quarter 3 reporting (target 20%) by achieving 67% of patients who met the screening criteria going on to be screened. This has been due to the careful planning, staged roll out, continuous education and engagement exercises, and support from staff behind the scenes and on the front line.

Future goals for next financial year (2016/2017): We will continue to work on the early identification and treatment of patients who are at risk of sepsis on arrival to the hospital. In addition, we will also be looking at 'appropriate' antibiotic prescribing and antibiotic review within 72 hours.

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.

Targets set for financial year (April 2015/March 2016): **Partially Achieved**

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

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

The projects on Sepsis and Acute Kidney Injury are **priorities for improvement**

Improvements delivered in financial year (April 2015/March 2016): A working group has been established, pilot sites have been identified, a training simulation group has been established and work is ongoing to develop an IT solution for extracting information from our Laboratory Information Management System to enable us to alert clinicians, the critical care outreach team and nephrology to the fact their patient has AKI and the management plan to be implemented.

Future goals for next financial year (2016/2017):

- Refine transfer of information between healthcare sectors in patients with AKI (content, messaging and coding).
- Support existing task and finish groups (Educational workshops, attendance at project meetings and roll-out of AKI alerts). Establish links and governance structures to support awareness and QI in AKI in other Sussex CCGs.
- Support education and co-design of pathways for risk management, AKI avoidance and early recognition in out-of-hours service, care homes and community pharmacies.

Communicating and learning from patients: Patients' Voice

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



In addition we seek regular and real time feedback from patients and their representatives at the bi-monthly Patient Experience Panel. We actively engaging with the public to give feedback through representative groups such as; Lesbian, Gay, Bi-sexual and Transgender Health Improvement Partnership, Healthwatch, Speak Out (Learning Disability Advocacy) and the Carer's Centre, this gives us the opportunity to obtain our patients' views on the services we provide and also invites their input into service developments and improvements.

For inpatients the Patients' Voice survey has been adapted to incorporate the National Friends and Family Test (FFT). The FFT question of whether you (the patient) would recommend this hospital to a relative or friend is also asked in A&E, Children's services, Daycase and Out patients. Our Complaints and Patient Advice and Liaison Service (PALS) teams work closely together to identify emerging themes from the informal and formal concerns received. The teams work closely with the specialities to ensure that lessons are quickly learnt from any reported poor patient experience.

Part 2

Targets set for financial year (April 2015/March 2016): **Achieved**



To ensure the Trust's FFT scores are better than the national average. At the end of February 2016 (latest available data) nationally the proportion of inpatients recommending their hospital was 96%. In BSUH this figure was 98%. In A&E the national figure was 85% whilst for BSUH 88% of patients would recommend the department. In maternity the national figure was 95% as was BSUH. In Outpatient departments the national figure was 93% whilst for BSUH 95% of patients would recommend the department.

Improvements delivered in financial year (April 2015/March 2016): The most significant improvement in the 2015/16 was the introduction of texting and interactive voicemail in the A&E departments with the monthly return rate rising from 3.8% return rate in April 2015 to 18.9% return rate in February 2016 (national average 13.3%).

The patient experience panel has more diverse representation from groups across Brighton and Sussex and is independently chaired by the CEO of Healthwatch, Brighton and Hove. Public and patient led wayfinding project is being implemented.

Future goals for next financial year

(2016/2017): Implement an electronic system for collecting Friends and Family data across all areas, which has a user friendly interface to ensure that the feedback is being actively used at ward and department level. To expand the membership of the Patient Experience Panel and develop other ways of engaging the public in developing our services.

Improving the prevention of pressure damage

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

Targets set for financial year (April 2015/March 2016): **Achieved**



This year we have achieved a total reduction in pressure damage of 12.2%. The overall incidence of reported pressure damage is the lowest we have ever achieved at BSUH.

Improvements delivered in financial year (April 2015/March 2016): We believe that the reduction in pressure damage has been achieved by highlighting and discussing with staff of all disciplines that if the basics of care are performed well, complex wounds developing that require significant amounts of time and resources may be avoided.



Future goals for next financial year

(2016/2017): This year we have spent a significant amount of time examining events that have led to patients developing pressure damage. Our goal for next year is to start targeting patients that present with high risk and ensure that all care needed is being delivered. We will trial having a dedicated Nurse who will help assess high risk patients and educate the staff at the bedside to ensure the right care is given at the right time. The extended service will be guided by all the lessons we have learnt in the last year in an effort to further reduce the incidence of pressure damage. As worldwide research into pressure damage continues we are beginning to understand more and are therefore able to take a more pragmatic approach, however at BSUH we strongly believe that whether a pressure ulcer is avoidable or unavoidable we must be able to reassure our patients and ourselves that we have made every effort to keep our patients safe. A target rate of 0.41 pressure damage incidents per 1000 bed stay days has been set for 2016-17. If achieved this would be 10% reduction in the pressure damage rate.

Towards a more engaged workforce

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



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

Targets set for financial year (April 2015/ March 2016): Partially Achieved

The ambition for 2015-16 was to provide a forum for the presentation of new ideas at four innovation forums during the year. This was achieved with events being held in January and the end of April, with a third event planned for July 2016.

Part 2

Improvements delivered in financial year (April 2015/March 2016): Six new ideas were proposed during the year. These included a project on incorporating point of care barcodes to security badges from the Point of Care Team; a medical student suggestion to create a database of all research being completed at BSUH to improve collaboration; and an improved service to improve communication with, and support for, families following head injury.

Presented ideas included a proposal for an alcohol withdrawal identification tool from an A&E Nurse; To take out (TTO) stickers to ensure all patients are informed about the medications they are discharged on from the pharmacy technicians; and an oxygen warning wristband for patients who are at risk of being over-oxygenated into respiratory failure.

We were pleased to hear progress reviews from the Critical Care Outreach Team, who won an award at the KSS AHSN Expo & Awards 2016 following the development of their idea for medical emergency team meetings through the Innovation Forum.

Future goals for next financial year (2016/2017): Following a rebranding in March 2016 the IF Steering Group plans to continue efforts to raise the profile of the forum and this year is hoping to receive over ten submissions from professional groups across the organisation.

Reducing hospital acquired infection

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

Targets set for financial year (April 2015/March 2016): Not achieved

The trajectory for MRSA bacteraemia and Clostridium difficile infections are set nations. For 2015/16 the Trust trajectory was:

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

We had:

- One avoidable MRSA bacteraemia
- 47 Trust acquired cases of Clostridium difficile infection

Improvements delivered in financial year (April 2015/March 2016): Whilst the Trust breached their annual trajectory by one case, the Trust did see more cases in June 2015 than expected. A significant amount of work has been undertaken to identify the cause of this and the actions required to improve our performance. As a result the Trust saw a significant reduction in the monthly rate of Trust acquired Clostridium difficile infection cases, which was maintained.



The Towards a safer hospital project has been superseded by the **'Right Care, Right Place, Each Time'** initiative which is a priority for improvement

The Trust has also experienced outbreaks of Norovirus and Influenza, which has put pressure on the Trust bed capacity and has impacted on patient flow. Control measures were implemented and were reviewed and monitored throughout the outbreak so that the spread of infection was minimised, where possible to ensure the safety of our patients, visitors and staff.

Future goals for next financial year (2016/2017): The trajectory for MRSA bacteraemia and Clostridium difficile infections is set nationally. For 2016/17 the Trust trajectory was:

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

Patient transfer

At any point where there is a handover of care between individuals or teams there is a risk of information being lost which could negatively affect patient care. The timing of patient transfers is also important in terms of safety and patient experience along with ensuring appropriate escort. This project forms part of the Towards a safer hospital project.

Towards a safer hospital

Frontline clinical staff have identified areas for improvement during their day-to-day work that will make a real impact to patients by ensuring safe care. The projects have been developed by frontline clinical staff and supervised by clinicians with expertise in quality improvement and 'human factors'.

Projects included in this are: towards a safer ward (ward round checklist), towards a safer transfer, towards a safer handover, towards a safer operating theatre, towards a safer emergency department. The Towards a Safer Hospital Programme is being reviewed. The data visualisation tool will continue to be developed and reviewed by the Safety and Quality Committee.

Targets set for financial year (April 2015/ March 2016): Partially **Achieved**

Improvements delivered in financial year (April 2015/March 2016): The 'Towards a safer hospital' projects have been superseded by a project known as 'Right Care, Right Place, Each Time'. This project aims to improve the safety and efficiency of wards and discharge processes in order to improve the flow of patients through the hospital, which in turn allows patients requiring urgent treatment to access care quicker. The project includes elements of multidisciplinary handover ('Board Rounds') and minimising transfers between wards by ensuring patients access the correct ward first time. Other elements of the 'towards a safer hospital' project will be dealt with as specific projects. As well as the implementation of the Right Care project, achievements in 2015/6 include achieving 90% compliance with all elements of the World Health Organisation safer surgery checklist.

Future goals for next financial year (2016/2017): Future goals for next financial year (2016/2017): This project has now been absorbed within the 'Right Care, Right Place, Each Time' initiative.

Part 3



Part 3

Statements of quality of NHS services provided

The information in this section is mandatory text that all NHS Trusts must include in their Quality Account.

Review of services

During 2015/16 Brighton & Sussex University Hospitals NHS Trust provided acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups and NHS England. £430.6m of our income came from Clinical Commissioning Groups and NHS England for patient care activity. The income generated by the NHS services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of NHS services by Brighton and Sussex University Hospitals NHS Trust for 2015/16.

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

Performance against 2015-16 core set of indicators

The following section shows how the Trust has performed against a core set of indicators and, within the data, there are comparisons with the best and worst performing teaching hospitals. A combination of external lists and knowledge within the Trust has been used to identify these comparator hospitals, most of which are members of the Association of UK University Hospitals.

The information on the data sources is available via <https://indicators.ic.nhs.uk/webview/>

Part 3

Patient Reported Outcome Measures (PROMs)

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

	(i)	(ii)	(iii)	(iv)
BSUH rate	0.088	0.097	0.411	0.288
National average	0.084	0.095	0.437	0.315
Best performing teaching hospital	0.102	0.127	0.457	0.329
Worst performing teaching hospital	0.027	-0.002	0.401	0.262

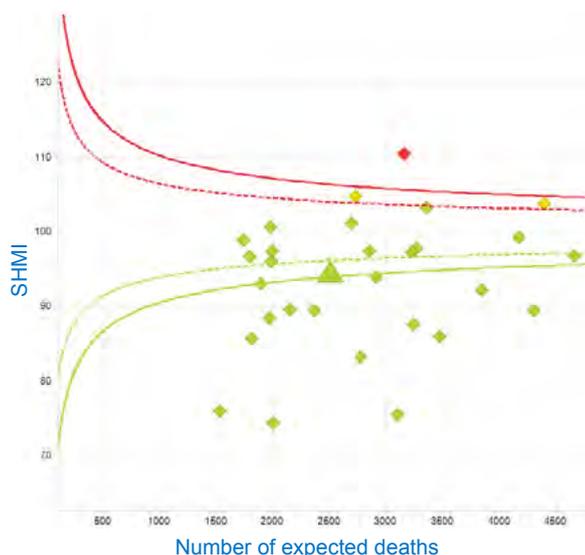
The Trust considers this data is as described because it has been taken from a national data set and the Trust's participation rate is high, meaning that the data are reliable. The Trust's PROMs for groin hernia surgery and varicose vein surgery are higher than the national average. Although the outcomes for hip and knee are lower than the national average, it is believed that the measures are not sensitive enough to adequately account for the patient casemix at the complex end of the spectrum of patients that are treated at this Trust. Nevertheless, the Trust's rate for hip replacement has improved since the previous year. PROMs data is kept under review by the Directorate Safety and Quality meeting.

Summary Hospital-Level Mortality Indicator

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

	2014/15	2015/16
BSUH rate	0.9423	'Lower than expected' (0.9465)
National average	1.0000	'As expected' (1.0000)
Best performing teaching hospital	0.7547	'Lower than expected' (0.7435)
Worst performing teaching hospital	1.1857	'Higher than expected' (1.1049)

The Trust considers that this data is as described because it is taken from the national dataset. The Trust has taken actions to improve this rate, and so the quality of its services, by routinely monitoring mortality rates. This includes looking at mortality rates by speciality, diagnosis and procedure. A systematic approach is adopted whenever an early warning of a problem is detected and the Executive Safety and Quality Committee and Board Quality and Risk Committee routinely scrutinises this data and receive six monthly reports on any concerns identified. This work is supported by our Coding Department to ensure any clinical and non-clinical concerns are identified.



A SHMI score is calculated based on all hospital deaths and those who die within 30 days of a hospital admission. A SHMI score of 100 indicates there is no difference between the hospital's mortality rate and the national average rate. If the score is greater than 100 this indicates that more patients than expected died. The SHMI score of 94.6 indicates that the Trust had 5.4% fewer deaths than expected, 2369 patients died against an expected number of 2503 patients.

Rate of C.difficile infection

The number of Trust-acquired cases of C. difficile infection that have occurred within the Trust amongst patients aged two or over during the reporting period. The Trust considers this data is as described because every case is scrutinised weekly by the Trust's Infection Prevention and Control Action Group and reported externally. While the Trust's rate is higher than the national average, there has been a year-on-year reduction. The weekly Infection Prevention and Control Action Group (IPAG) reviews the investigations and learning from all cases of C. diff and monitors progress with the agreed actions.

	Number of cases	2015-16 rate	2014-15 rate
BSUH	47	17.42	16.70
National average	61	17.63	18.98
Best performing teaching hospital	9	6.78	3.80
Worst performing teaching hospital	139	34.15	40.50

The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period. Comparative data is benchmarked against non-specialist university hospitals that are members of The Association of UK University Hospitals.

Responsiveness to the personal needs of patients

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

	2014/15	2015/16
BSUH rate	63.8	69.2
National average	68.7	68.9
Best performing teaching hospital	77.3	76.8
Worst performing teaching hospital	58.8	63.7

The Trust considers this data is as described because it is produced by the Picker Institute in accordance with strict criteria. An action plan that addresses the issues raised in the National Patient Survey has been developed and has been overseen by the Trust's Patient Experience Panel.

Part 3

Patients readmitted to a hospital within 28 days of being discharged

The percentage of patients readmitted to a hospital within 28 days of discharge during the reporting period aged: (i) 0 to 15; and (ii) 16 or over. The data comes from a national benchmarking tool and measures April 2015 to January 2016.

	2014/15		2015/16	
	(i)	(ii)	(i)	(ii)
BSUH rate	9.97	12.94	7.37	8.02
National average	8.76	11.86	8.52	7.12
Best performing teaching hospital	5.86	10.64	Not available	Not available
Worst performing teaching hospital	12.5	13.55	Not available	Not available

The Trust considers that this data is as described because it taken from the national dataset. One of the indicators is worse than the national average and this is an area we will address in 2015/16 by improving patient flow through our ten high impact programmes.

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

The number and rate of patient safety incidents that occurred within the Trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death: i) rate of incidents reported per 1000 bed days, ii) rate of incidents resulted in severe harm or death per 1000 bed days, iii) number of incidents resulting in severe harm or death, iv) Percentage of reported patient safety incidents resulting in severe harm or death.

	(i)	(ii)	(iii)	(iv)	(iv) 2014/15
BSUH rate	29.94	0.047	13	0.16%	0.30%
National average	38.78	0.122	44	0.33%	0.49%
Best performing teaching hospital	22.57	0.047	13	0.11%	0.07%
Worst performing teaching hospital	61.94	0.329	151	0.91%	1.49%

The Trust considers that this data is as described because a panel of consultants reviews this data weekly in order to ensure every incident is appropriately graded. The data is derived from the National Reporting and Learning System for patient safety incidents. Because there is a delay in this data being reported, the data covers the second half of 2014/15 and the first half of 2015/16. Comparative data is benchmarked against non-specialist university hospitals that are members of The Association of UK University Hospitals.

Patients admitted to hospital who were risk assessed for venous thromboembolism

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period. The Trust considers the data is as described because it is routinely scrutinised at the monthly Executive Safety and Quality Committee. The Thrombosis Committee continues to monitor progress and practice regarding VTE risk assessment and any required improvements.

	Number of cases	2015/16 rate	2014/15 rate
BSUH rate	47	17.42	16.70
National average	61	17.63	18.98
Best performing teaching hospital	9	6.78	3.80
Worst performing teaching hospital	139	34.15	40.40

Patients who would recommend the Trust to their family or friends

The Trust's score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care in: (i) A&E; (ii) Inpatient areas; (iii) Antenatal care; (iv) Birth; (v) Postnatal ward; (vi) Postnatal Community Care. The Trust considers this data is as described because we have developed a systematic approach to the collection of the Friends and Family Test scores through our internal patient survey 'Patients' Voice'. The results of the FFT are shared with all services through staff and clinical governance meetings to drive improvements in practice.

	2014/15			2015/16		
	(i)	(ii)	(iii)	(i)	(ii)	(iii)
BSUH rate	77.7	92.7	96.9	88.6	94.3	98.6
National average	86.8	94.2	96.6	87.4	95.3	94.7
Best performing teaching hospital	98.8	99.6	100.0	96.2	98.3	100.0
Worst performing teaching hospital	67.1	78.5	40	70.3	88.2	87.1

	2014/15			2015/16		
	(iv)	(v)	(vi)	(iv)	(v)	(vi)
BSUH rate	98.3	97.3	97.0	98.7	97.5	97.7
National average	95.8	92.2	96.6	96.7	93.5	97.6
Best performing teaching hospital	100.0	98.8	100.0	99.6	98.3	100.0
Worst performing teaching hospital	79.3	72.8	75.1	90.7	87.2	90.1

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 NHS service they work in to friends and family as a place to work.

	2014/15	2015/16
BSUH rate	69.65	54.3
National average	76.52	64.9
Best performing teaching hospital	94.62	78.1
Worst performing teaching hospital	52.4	46.4

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the NHS service they work in to friends and family who need similar treatment or care.

	2014/15	2015/16
BSUH rate	69.7	69.0
National average	76.5	82.6
Best performing teaching hospital	94.6	96.4
Worst performing teaching hospital	52.4	69.0

We consider this data is as described because the exercise is undertaken by an external organisation with adherence to strict protocols around sample size and selection. A detailed plan has been developed to address the findings of the survey with a focus on improving staff engagement.

Part 3

Participation in national clinical audits

The national clinical audits that Brighton and Sussex University Hospitals NHS Trust participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The Trust participated in 48 of the 52 applicable national clinical audits. Where the Trust did not participate in a national clinical audit, the reasons are also described below. This includes the National Cardiac Arrest Audit (NCAA) where the national audit is less comprehensive than the local audit we have had in place for a number of years. The reports of the national clinical audits detailed below were reviewed by the provider in 2015/16 and Brighton and Sussex University Hospitals NHS Trust intends to take the actions described in this section of the report to improve the quality of healthcare provided.

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 99%

Action taken or planned to improve quality of healthcare: The data has been used to monitor the impact of service redesign to facilitate direct patient entry into the cardiac catheter labs and these targets are now achieved. It is also used to inform review of cases where delays have been seen and take forward any issues.

Adult Asthma

Eligible: Yes

BSUH Participation: Audit takes place Sept-Oct 2016

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: Data collection is scheduled to take place from September 2016.

Adult Cardiac Surgery

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: 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.

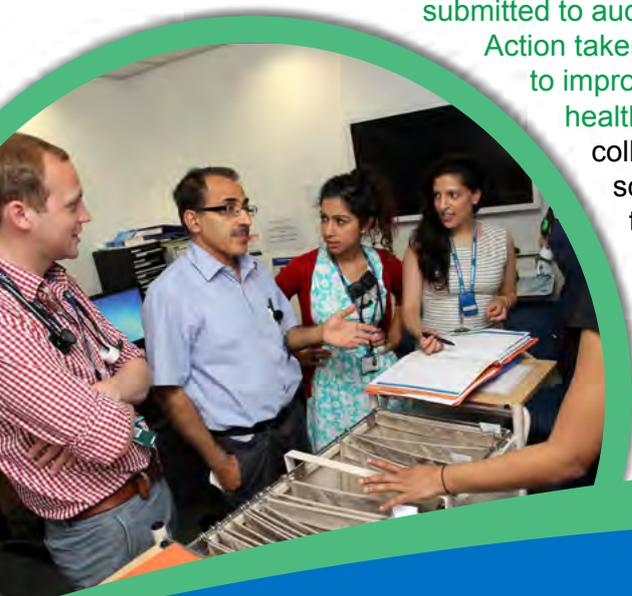
Bowel Cancer (NBOCAP)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 89%

Action taken or planned to improve quality of healthcare: Overall adjusted 90 day mortality is well within national limits and our 90 day unplanned hospital readmission rate is lower than the national rate. The screening service is better than the national rate and is expanding. An area that requires improvement is around the waiting time for stoma reversal surgery which is currently too long for many patients.





Cardiac Rhythm Management (CRM)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 99%

Action taken or planned to improve quality of healthcare: Results are reviewed regularly at the cardiac clinical governance meetings and are used to provide a starting point for relevant local audits.

Case Mix Programme (CMP)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Reports are circulated amongst the directorate and are used for benchmarking purposes.

Congenital Heart Disease (CHD)

Paediatric

Eligible: No

BSUH Participation: N/a

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: Paediatric cardiac surgery is not undertaken at the Trust and therefore this element of the national audit is not relevant.

Adult

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: All eligible cases are uploaded to the National Institute for Cardiovascular Outcomes Research (NICOR) database and then 40% are audited by a dedicated team at NICOR in order to validate the data.

Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 99%

Action taken or planned to improve quality of healthcare: All patients are entered onto a dedicated database after their procedure and all consultant operators have their data published online, available for public scrutiny.

Diabetes (Paediatric) (NPDA)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The percentage of children (27.8%) with good control is higher than the national average (21.9%) and the percentage of children (19.7%) with poor control is lower than the national average (21.5%). Patient satisfaction has been significantly above the regional and national averages in all categories.

Elective Surgery (National PROMs Programme)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 87%

Action taken or planned to improve quality of healthcare: The latest overall participation rate of 87.2% is now much higher than the England average of 75.4%, reflecting significant efforts made over the last two years to increase participation.

Part 3

Emergency Use of Oxygen

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Ward-by-ward analysis has been undertaken and is being shared with all the wards involved. Some wards had a higher than average number of patients on oxygen without a prescription being documented and therefore will require improvement and further monitoring. The results showed that most wards were performing very well in terms of regular and appropriate recording of oxygen saturations for patients who were on oxygen.

Falls and Fragility Fractures Audit programme (FFFAP)

Fracture Liaison Service Database

Eligible: No

BSUH Participation: N/a

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: A Fracture Liaison Service/Falls Prevention Service is provided by the Sussex Community Trust and therefore we are not eligible to participate.

Inpatient Falls

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: We are currently in the top five performing Trusts for falls prevention and top in the Kent, Surrey and Sussex region. This reflects the significant work that has been done to embed a culture of debriefing and reflection with staff following a patient fall. Areas identified for improvement are establishing an approach that will make undertaking of lying and standing blood pressure measurement routine; incorporating the audit of bed rail use into the monthly nursing metrics tool; and including an audit of whether call bells are in patients' reach.

National Hip Fracture Database

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Data completeness and ongoing monitoring is undertaken continuously throughout the year and measures show higher than average performance.

We are currently in the
**top five performing
Trusts in the country**
for falls and the top in
the Kent, Surrey and
Sussex region



Inflammatory Bowel Disease (IBD) Programme

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: There was no national audit of inpatient care taking place this year, but the national audit of biological therapies did take place and BSUH participated. An ongoing programme of improvements continues within the department for patients with IBD, with many of those improvements being realised through the establishment of a super-clinic at which all the multidisciplinary team are present. It is expected that patients will have an improved experience through this clinic.

Major Trauma Audit

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Recent work includes the development of a new database to allow more robust data collection and review in the future. Other improvements include the development of Trust standard operating procedures for the delivery of key components of clinical care and new documentation being developed for use in the emergency department and Major Trauma Centre.

Maternal, Newborn and Infant Clinical Outcome Review Programme

Perinatal Mortality Surveillance

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Data shows up to 10% lower deaths than similar hospitals with gestations 24-28 weeks and 28-32 weeks. Neonatal deaths are reviewed at the following weekly clinical meeting. In cases where there is a post-mortem, the death is reviewed at the three monthly Clinical Governance meeting.

Perinatal mortality and morbidity confidential enquiries

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: From January 2016 the care of every baby that dies from 24 weeks are reviewed and investigated. Appropriate actions are taken based on the findings and themes are presented every three months.

Maternal morbidity and mortality confidential enquiries/Maternal mortality surveillance

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: We attended the launch of this report are undertaking a review of the key recommendations to benchmark and set out an action plan for any identified gaps.

Part 3

Medical and Surgical Clinical Outcome Review Programme

Mental Health

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: Data collection currently ongoing

Action taken or planned to improve quality of healthcare: N/a

Acute Pancreatitis

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 90%

Action taken or planned to improve quality of healthcare: Awaiting publication.

Sepsis

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The Sepsis screening tool has been launched for patients in the Emergency Department and we have practice educators working in the departments. The children's hospital has a lead consultant and nurse delivering training and raising awareness. We are encouraging sepsis champions in all clinical areas and we continue to progress the national Sepsis CQUIN to promote improvements in the identification and care of patients with Sepsis.

Gastrointestinal Haemorrhage

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The named consultant gastroenterologist on call is responsible for GI bleeds out of hours and there is a seven day ward round for the care of current patients. There is also 24/7 access to endoscopy services.

National Cardiac Arrest Audit (NCAA)

Eligible: Yes

BSUH Participation: No

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: Participation requires the Trust to subscribe to the NCAA. To date, the Resuscitation Operational Management Group has decided not to subscribe as it is costly with no real benefit to the Trust. Instead, we carry out an annual local audit that is more comprehensive than the national audit and therefore more valuable. Results of the local audit are consistently high.

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme

Secondary Care and Pulmonary Rehabilitation workstreams

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: >70%

Action taken or planned to improve quality of healthcare: Two COPD Clinical Nurse Specialists have been recruited, significantly improving the opportunities available to refer patients to community rehabilitation services, smoking cessation and pulmonary rehabilitation.



National Comparative Audit of Blood Transfusion Programme

Audit of Patient Blood Management in Scheduled Surgery

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: Not available

Action taken or planned to improve quality of healthcare: Case ascertainment for this audit was extremely difficult due to lack of a computerised system that would allow relevant patients to be identified. This meant very large numbers of case notes had to be reviewed to determine whether patients were eligible for inclusion in the audit, which was time-consuming and not sustainable.

National Complicated Diverticulitis Audit (CAD)

Acute surgical services

Eligible: No

BSUH Participation: No

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: We did not participate in the first year of this national audit and is therefore not eligible to take part in the latest round. The Trust intends to participate in the future if the audit be repeated.

National Diabetes Audit - Adults

National Footcare Audit

Eligible: Yes

BSUH Participation: No

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: We registered during 2015/16 to participate in this workstream and have yet to submit data to the audit.



The proportion of inpatients with diabetes seen by a member of the diabetes team has **risen to 51.1% against a national average of 35%**; errors of medication, prescription, management and insulin have all **fallen**; and **patient satisfaction is at 95%**

National Inpatient Audit

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The latest audit showed a number of significant improvements at the Royal Sussex County Hospital. The results re-emphasised the need to improve the inpatient foot service and this remains a priority. Some improvements were also noted at the Princess Royal Hospital but not as consistently and this is something the team will need to address.

Part 3

National Pregnancy in Diabetes Audit

Eligible: Yes

BSUH Participation: No

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: We have previously not participated in this workstream but with the arrival of a new Consultant in 2015 with responsibility for diabetes and pregnancy, recruitment of patients to this audit started in the Autumn of 2015.

National Core

Eligible: Yes

BSUH Participation: No

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: Technical difficulties with the databases used for collecting and extracting the data prevented the Trust from submitting data to this round of the national audit.

National Emergency Laparotomy Audit (NELA)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 89%

Action taken or planned to improve quality of healthcare: Many improvement initiatives have been undertaken with a particular focus on improved sepsis screening and appropriate antibiotic administration. A new sepsis screening tool has been developed, which prompts earlier senior review of a patient, and clarifies the appropriate process to follow for septic patients. Improved categorisation of the emergency surgery list according to urgency is also helping to reduce the time to surgery for relevant patients.

National Heart Failure Audit

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The Enhancing Quality programme now receives data in a timely way that is site specific and allows comparison with other sites within the Kent, Surrey and Sussex area. The data has been used to support the case for an additional heart failure consultant and specialist nurse at the Princess Royal Hospital which are being recruited to.

National Joint Registry (NJR)

Knee and Hip replacements

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Dramatic improvements that have been made in recent years have been sustained and we are working towards implementing a new database which will allow more detailed analysis to be carried out, which in turn will facilitate further improvements.



National Lung Cancer Audit (NLCA) Lung Cancer Consultant Outcomes Publication

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The service has undergone further redesign and we anticipate real patient benefits, particularly in allowing the clinician who first meets the patient to be able to explain the steps required to obtaining a diagnosis. It will avoid multiple rediscussions and allow for a more streamlined decision-making process regarding treatment.

National Ophthalmology Audit Adult Cataract surgery

Eligible: Yes

BSUH Participation: Audit not started at time of writing

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: This audit is scheduled to start in April 2016.

National Prostate Cancer Audit

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 68%

Action taken or planned to improve quality of healthcare: Data not available

National Vascular Registry

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 98-99%



Caring for our lung cancer patients

The Clinical Nurse Specialists have set up a patient group which meets monthly for patients to share their experiences with other patients and their families or carers. This is proving to be extremely popular and valued by our patients. We also have the “living with lung cancer” holistic clinic which remains a valuable resource for patients to access nutritional advice, expert physiotherapy review and Citizens Advice Bureau support. The feedback collected has been excellent and this remains one of the best holistic clinics available in lung cancer nationally.

Action taken or planned to improve quality of healthcare: The department aims for 100% submission of data but this is not always achieved due to some missing compulsory data items and difficulties obtaining the casenotes when they are required.

Neonatal Intensive and Special Care (NNAP)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Projects are underway in the department to improve admission rates for hypothermia and hypoglycaemia as well as performance of screening for retinopathy of prematurity.

Part 3

Non-Invasive Ventilation - Adults

Eligible: Yes

BSUH Participation: Audit did not take place in 2015/16 and is not currently scheduled to take place during 2016/17

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: Although a national audit has not taken place recently, some very comprehensive data has been collected during 2015 and a working group has been established in order to address some important issues.

Oesophago-gastric Cancer (NAOGC)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 71-80%

Action taken or planned to improve quality of healthcare: Data not available

Paediatric Asthma

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The data collection period for this audit closed on 28 February 2016 and the report is awaited.

Paediatric Intensive Care (PICANet)

Eligible: No

BSUH Participation: No

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: The paediatric critical care data ceased to be collected from Jan 2015 because we are not a Level 3 paediatric critical care unit.

Paediatric Pneumonia

Eligible: Yes

BSUH Participation: Audit not yet started

Percentage of eligible/required cases submitted to audit: N/a

Action taken or planned to improve quality of healthcare: This audit is scheduled to start in November 2016 and we intend to participate.

Procedural Sedation in Adults (care in emergency departments)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 92%

Action taken or planned to improve quality of healthcare: Results of the audit showed documentation was poor and not compliant with the agreed practice. We are developing an electronic database to log all sedations carried out in the department and to ensure the correct information is documented. The national audit has also prompted a local audit to look at how many procedural sedations are being done that are not correctly logged.

Renal Replacement Therapy (Renal Registry)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The Sussex Kidney Unit holds regular Clinical Governance Meetings each year, at which there is always an audit presentation resulting in the development of an action plan, reviews of all renal deaths and presentations of after-action reviews of any cases that are of concern.

Rheumatoid and Early Inflammatory Arthritis

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: Not available

Action taken or planned to improve quality of healthcare: Processes are underway to recruit 1.5 consultants and improvements have been achieved in the booking system. Booking processes will continue to be monitored in the future to ensure patients are booked into the most appropriate clinics.

Sentinel Stroke National Audit programme (SSNAP)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: >90%

Action taken or planned to improve quality of healthcare: Steps have been taken to maximise the therapy time available, through changing multidisciplinary team meetings times to allow further opportunities for patient contact; using a handover board to try to bring forward any discharges and plan practical points to discharge; and providing shared therapy sessions for up to four patients at a time to increase therapy input.

UK Cystic Fibrosis Registry

Paediatric

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: The UK Cystic Fibrosis Registry is a secure centralised database that records health data on consenting people with cystic fibrosis.

UK Parkinson's Audit Physiotherapy

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: Awaiting publication of the results of the audit.

Vital signs in children (care in emergency departments)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: We have implemented compulsory recording of details on the electronic record system, including the Paediatric Early Warning Score (PEWS), and hourly observations on all children in the Children's Emergency Department who are on PEWS charts.

VTE risk in lower limb immobilisation (care in emergency departments)

Eligible: Yes

BSUH Participation: Yes

Percentage of eligible/required cases submitted to audit: 100%

Action taken or planned to improve quality of healthcare: A poster is being developed for display in clinical areas of the urgent care centre, highlighting the need to include written evidence that a VTE assessment has been undertaken; to raise awareness of the need for VTE prophylaxis in patients who have a backslab as well as for those who have a plaster cast; and to remind staff to provide relevant patients with a leaflet that details the risk, symptoms to look out for and when to seek medical attention.

Part 3

Participation in local clinical audits

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

Accident and Emergency

Project title: Missed radiology in the emergency department

Actions to improve the quality of care: Better filtering of normal scans; all discharges to have a six-week follow up recommended if abnormal chest pathology; doctors to ensure scan abnormalities are recorded.

Anaesthetics

Project title: Hip fracture - continuous QIP

Actions to improve the quality of care: Reduction in 30 day mortality from 11% in 2007 to 3.7% in 2014 (lowest in UK) compared to national average of ~8%; reductions in length of stay; improvements in and standardisation of anaesthesia technique.

Project title: Anaesthesia sprint audit of practice

Actions to improve the quality of care:

Currently working on a national campaign to standardise anaesthesia technique (low dose spinal anaesthesia with reduced sedation and close blood pressure monitoring); ASAP data collection fields incorporated into Brighton Hip Fracture Database.

Biochemistry

Project title: Spurious hyperkalaemia audit

Actions to improve the quality of care: Incorrect sample refrigeration at Lewes Prison medical unit discontinued and sample transport reviewed.

Cancer

Project title: Unscheduled treatment interruptions in radiotherapy including cat 1 patients

Actions to improve the quality of care: The majority of patients treated as per protocol/guidelines; cat 1 patients well within tolerance permitted by cancer peer review.

Cardiology

Project title: What are the causes of delay for patients undergoing cardioversion for atrial fibrillation?

Actions to improve the quality of care: Recommendations relate to improving communication and counselling when commencing anticoagulation, to consider screening for sinus rhythm in the week.



Dermatology

Project title: Management of squamous cell carcinoma at Brighton General Hospital.

Actions to improve the quality of care:

Performance status now routinely listed on histology forms or in notes, also needed for Multidisciplinary discussion.

Diabetes/Endocrinology

Project title: Diabetes inpatient audit

Actions to improve the quality of care: New clerking proforma will have a prompt to perform a foot examination on all admission with diabetes.

Project title: Audit of outcomes of pituitary surgery

Actions to improve the quality of care: Change of policy - patients kept under Combined Pituitary Clinic for two post-operative visits rather than one, prior to discharge to local endocrine follow-up where appropriate, to ensure all outcomes reviewed.

Project title: UK acromegaly register and audit of outcomes of patients treated for acromegaly

Actions to improve the quality of care: All patients with acromegaly who have not reached biochemical targets are discussed by the multidisciplinary team at least annually.

Dietetics and Nutrition

Project title: Assess amount of prescribed enteral feed received by neurology patients on critical care

Actions to improve the quality of care: Working with Trauma Network across UK to compare best practice to increase the amount of prescribed feed that is delivered to the patient.



Digestive Diseases

Project title: Quality of operative notes in elective patients operated on at Princess Royal Hospital and emergency patients operated on at the Royal Sussex County Hospital

Actions to improve the quality of care: To produce a specially standardised proforma, setting the recommendations as a minimal standard and keeping in mind the already existing proforma as a simple and inexpensive method for improving the quality of operative notes.

Elderly Medicine

Project title: Investigating the prevalence of vitamin D deficiency in older patients admitted under geriatric medicine teams

Actions to improve the quality of care: Add Vitamin D level assays to GAPS and add GAPS to the Emergency Department group pathology requests. Findings and actions plans presented to elderly medicine department.

Part 3

HIV/AIDS Services

Project title: Management of non-specific urethritis

Actions to improve the quality of care: Local guidelines developed for the management of persistent urethritis including routine testing for new organism.

Imaging

Project title: Improve radiation dose in the interventional radiology suite

Actions to improve the quality of care: To use a radiation dose World Health Organisation safety check list before the interventional radiology procedures to minimise patient's and radiologist's radiation dose.

Infection Control

Project title: Source isolation of patients with diarrhoea

Actions to improve the quality of care: Over half of the patients were not source isolated within 12 hours of the specimen being taken. This poses a risk of cross-infection. The audit will be repeated with a view to focusing on inpatients post 72 hours admission and a separate audit undertaken on areas such as the acute medical units.

Intensive Care Unit

Project title: Documentation of daily microbiology ward round

Actions to improve the quality of care: New standard operating procedure for microbiology ward rounds to allow real-time documentation at the workstation.

Neonatology

Project title: Non-invasive respiratory management audit

Actions to improve the quality of care: Current guidance is being adjusted to reflect new developments in non-invasive respiratory management.

Pharmacy

Project title: An audit of hypersensitivity reactions following subcutaneous trastuzumab (Herceptin) injection

Actions to improve the quality of care: Observation time reduced to 30 mins post cycle one and two only, meaning patients can leave earlier and capacity is released for other cases.

Trauma and Orthopaedics

Project title: Oozy wound audit

Actions to improve the quality of care: The oozy wound protocol has been rewritten.

Project title: Urinary retention at the Sussex Orthopaedic Treatment Centre

Actions to improve the quality of care: Bladder scanning in recovery and four hours post operatively; increased use of intermittent self catheterisation.



Statements from the Care Quality Commission

Brighton and Sussex University Hospitals NHS Trust (BSUH) is required to register with the Care Quality Commission and its current registration status is without conditions. BSUH has not participated in any special reviews or investigations by the CQC during the reporting period. CQC carried out an inspection of urgent and emergency services at RSCH on 22nd and 23 June 2015. CQC made an assessment of inadequate for both safety and well-led in their inspection report.

Their key findings were that they 'observed compassionate and good clinical care provided to patients by staff; the physical capacity and staffing numbers and skill mix did not support the timely assessment of patients arriving at the department; patients were not cared for in the most appropriate environment due to overcrowding in the emergency department and poor patient flow into the main hospital; and there was a lack of management capacity and effective board challenge and support had resulted in a lack of progress in addressing issues over the last 18 months'.

As a result of their findings the CQC stated that the trust must:

- Reduce the numbers of patients cared for in the cohort area within the emergency department (and the regularity with which congestion occurs in this area) and ensure timely assessment of patients arriving in the department.
- Ensure that appropriate staffing levels and skill mix is in place to meet the needs of the patients within the department and support the process of improvement.

- Enhance board level effectiveness to ensure progress with the emergency department improvement plans.

CQC carried out a comprehensive re-inspection in April 2016. In June 2016, CQC served a Section 29A Warning Notice on the Trust identifying the need for significant improvements to be made by 30 August. This concerns patient safety, privacy and dignity and providing care for patients in a more timely way. CQC also required improvements in the effectiveness of the Trust Board.



Part 3

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Brighton and Sussex University Hospitals NHS Trust in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 3356.

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

Brighton and Sussex University Hospitals NHS Trust was involved in conducting over 280 clinical research studies in 28 clinical specialities the most research active of which are Cancer, Cardiovascular Disease, HIV Medicine, neurological disorders, Surgery Rheumatology and Renal Disorders during 2015-16. There were 98 Consultants and over 200 nursing and support staff directly supporting this work.

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

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

As the regional teaching hospital our staff are heavily engaged in clinical trial and research project development as well as participating in national programmes of activity.





Use of the CQUIN payment framework

A proportion of the Trust's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015-16 and for the following 12 month period are available on request from della.morris@bsuh.nhs.uk.

NHS number and general practice code validity

The Trust submitted records from April 2015 to February 2016 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

– which included the patient's valid NHS number was:

- 98.4% for admitted patient care;
- 99.6% for out patient care; and
- 94.1% for accident and emergency care.

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

- 99.9% for admitted patient care;
- 99.9% for out patient care; and
- 99.8% for accident and emergency care.

Part 3

Data quality

Following an internal audit of data quality in 2015, a detailed action plan has been developed to address the audit findings. This will provide greater assurance to the Trust Board through enhanced data validation, processes to reduce error rates, and ongoing training and audit.

Information governance toolkit

Brighton and Sussex University Hospitals NHS Trust's Information Governance Assessment Report overall score for 2015/16 was 66% and was graded Green based on the following key:

Not
Satisfactory

Satisfactory
with plan of
improvement

Satisfactory
✓

Clinical error rate code

BSUH was not subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission.

Assurance from the Board

During 2015/16, the Trust provided a wide range of hospital services across two main hospital sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath, together with services at The Park Centre for Breast Care; Hove Polyclinic; Lewes Victoria Hospital; Brighton General Hospital and Bexhill Hospital. We provide District General Hospital services to our local populations in and around the city of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the South East of England. The Trust has reviewed all the data available on the quality of care in all of these NHS services, through our performance framework and quality governance arrangements. The income generated by the NHS services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2015/16.



Part 4

Part 4

Statements from partners

Response from Brighton and Hove Clinical Commissioning Group

22 June 2016

Thank you for giving the Sussex CCGs; Brighton and Hove, Crawley, Horsham and Mid-Sussex, High Weald Lewes Havens, Eastbourne, Hailsham and Seaford, Hastings and Rother CCGs the opportunity to comment on your Quality Account for 2015/16.

The Quality Account appears to comply with the NHS England guidance on the content of the Account. The CCGs are pleased to see that the Quality Account priorities have taken into account both national and local community priorities.

Commissioners would like to acknowledge the work undertaken in improving pressure area prevention and the work the Trust has progressed to reduce harm from preventable falls and the lead they have taken in sharing their work locally and nationally.

We note the achievement of the 'EQR team and the Critical Care Outreach Team and their recognition of achievement at the KSS AHSN Expo and Awards 2016. We also recognise the clinical investigation team and the contribution made to the Sussex Quality Conference in November.

However we also know that the Trust requires improvement in a number of areas following the full CQC inspection of services in April 2016. At a time when services are under pressure, the outcome of the recent inspection will require a full commitment from all staff to collaboratively work as teams within the organisation and with external partners. As such, the CCG supports the Trust identifying as its top priority the implementation and delivery of the CQC improvement plan.

We are aware that the recent staff survey raised concerns and we would have liked to have seen more reference to the training, support and leadership development which will be required to see demonstrable improvements in patient quality and safety at pace. Increased visibility of the senior clinical and managerial leadership will be required to support the staff through this challenging time and we would have liked to have seen evidence of the way this will be enacted.

The commissioners are pleased to endorse this Quality Account for 2016/17 and we look forward to continuing our good relationships so we can all drive forward the quality improvements for our local populations.



Part 4

Directors' responsibilities

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

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

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



Dr Gillian Fairfield
Chief Executive



Antony Kildare
Interim Chairman

Auditors' report



Part 4

Glossary of terms and acronyms

Accident and Emergency (A&E) Service

A responsive service for patients in an emergency situation with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

ABI Acute Brain Injury.

ACU Ambulatory Care Unit.

Allied Health Professionals (AHP)

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

Advanced Medical Priority Dispatch System (AMPDS)

An international system that prioritises 999 calls using information about the patient as supplied by the caller.

Ambulance Quality Indicators (AQIs)

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

Any Qualified Provider (AQP)

When a service is opened up to choice of 'Any Qualified Provider', patients can choose from a range of providers, all of whom meet NHS standards and price.

Ambulance Service Cardiovascular Quality Initiative

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

AMU Acute Medical Unit.

Annual Assurance Statement

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

Automated External Defibrillator (AED)

A portable device used to restart a heart that has stopped.

Bare Below the Elbows

An NHS dress code to help with infection, prevention and control.

BAU Business as usual.

Better Payment Practice Code (BPPC)

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

BGH Brighton General Hospital.

Board Assurance Framework (BAF)

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

Board Governance Assurance Framework (BGAF)

The Board Governance Assurance Framework assists Boards through a combination of self and independent assessment processes to ensure they are appropriately skilled and prepared to achieve FT authorisation.

British Association for Immediate Care (BASICS)

A network of doctors who provide support to ambulance crews at serious road traffic collisions and other trauma incidents across the region.

British National Formulary (BNF)

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

Bronze Commander Training

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

BSMS Brighton and Sussex Medical School.

Caldicott Guardian

A senior member of staff appointed to protect patient information.

CAMHS Child and Adult Mental Health Service.

CAPEX Capital Expenditure.

Cardio-pulmonary Resuscitation (CPR)

A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.

Care Bundle

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

Care Quality Commission (CQC)

An independent regulator responsible for monitoring and performance measuring all health and social care services in England.

Catheter-acquired Urinary Tract Infection (CAUTI)

A bladder infection that has occurred as a direct result of the presence of an indwelling catheter (a mechanism used initially to help the bladder).

Central Sterile Service Department (CSSD)

A service that provides equipment sterilisation services.

Centre for Maternal And Child Enquiries (CMACE)

Aims to improve the health of mothers, babies and children by carrying out confidential enquiries and related work on a nationwide basis.

Part 4

Chartered Society of Physiotherapy (CSP)

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

Chairman

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

Chief Executive

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

Chronic Obstructive Pulmonary Disease (COPD)

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

CIRU Clinical Investigation and Research Unit.

Clinical Commissioning Groups (CCGs)

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

Clinical Hub

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

Clinical Pathways

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

Clinical Performance Indicators (CPIs)

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

Clinical Supervisor

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

CLN Community Link Nurse.

Clostridium Difficile (C.Diff)

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

CNS Central Nervous System.

Community Alcohol and Drug Service (CADS)

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

Community Equipment Store (CES)

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

Community First Responders (CFRs)

Volunteers in their local communities, who respond from their home addresses or places of work to patients suffering life-threatening emergencies.

Community Nursing and Therapy (CN&T)

Home delivered nursing, therapy services and interventions for Adults, such as wound dressings, end of life care and rehabilitation programmes.

Comprehensive Local Research Networks (CLRNs)

Coordinate and facilitate the conduct of clinical research and provide a wide range of support to the local research community.

Computer Aided Dispatch (CAD)

A method of dispatching ambulance resources.

Commissioning for Quality and Innovation (CQUIN)

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

Corporate Risk Register (CRR)

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

Cost Improvement Plan / Programme (CIP)

The formal identification of an action which reduces the budgeted cost base of the organisation. It can relate to either pay or non-pay costs.

COTE Care of The Elderly.

CSIC Cancer Support and Information Centre

CT Computed Tomography

DASH Disability and Specialist Health Pathway.

Data Protection Act 1998 (DPA)

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

Datix

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

Part 4

DDA Disability Discrimination Act.

Department of Health (DH)

The government department which provides strategic leadership for public health, the NHS and social care in England.

Deprivation of Liberty (DoL)

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

Electrocardiograms (ECG)

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

Electroencephalogram (EEG)

An electroencephalogram is a recording of brain activity.

Emergency Department (ED)

A hospital department responsible for assessing and treating patients with serious injuries or illnesses.

Emergency Preparedness, Resilience and Response (EPRR)

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

ENT Ear, Nose and Throat.

Equality and Diversity

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

EVAR Endovascular Aneurysm Repair.

FEVAR Fenestrated Endovascular Aortic Aneurysm Repair

FM Facilities Management.

Freedom of Information (FOI) Act 2000

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

FTT Family and Friends Test.

Foundation Trust (FT)

NHS organisations which operate more independently under a different governance and financial framework.

Foundation Trust Network (FTN)

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

General Practitioner (GP)

A doctor who is based in the community and manages all aspects of family health.

Governance

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

GUM Genito-Urinary Medicine.

Hazardous Area Response Team (HART)

A group of staff who are trained to deliver ambulance services under specific circumstances, such as at height or underground.

HCA Health Care Assistant.

HDU High Dependency Unit.

Healthwatch

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

Human Resources (HR)

A function with responsibility for implementing strategies and policies relating to the management of individuals.

ICU Intensive Care Unit.

Independent Mental Capacity Advocate (IMCA)

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

IM&T Information Management and Technology

Information Governance (IG)

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

IG Toolkit

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

Institute of Healthcare and Development (IHCD)

A body responsible for the content of some ambulance staff training which is then delivered through ambulance trusts.

Integrated Business Plan (IBP)

An IBP sets out an organisation's vision and plans to achieve that vision in the future.

Integrated Performance Report (IPR)

A report used to assure the Trust Board of organisational performance; to flag exceptions to the achievement of performance standards and corrective action as appropriate.

International Normalised Ratio (INR)

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

Part 4

ISO International Standards Organisation.

ITU Intensive Therapy Unit.

Key Performance Indicator (KPI)

A measure of performance.

Knowledge and Skills Framework (KSF)

A competence framework to support personal development and career progression within the NHS.

Learning Disability (LD)

A learning disability affects the way a person learns new things in any area of life. It affects the way they understand information and how they communicate.

Local Involvement Network (LINK)

A network of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. A new consumer champion called Healthwatch has started to replace LINKs from October 2012.

LPA Local Planning Authority.

Major Trauma

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

Major Trauma Centre (MTC)

A network of 22 new centres throughout the UK, specialising in treating patients who suffer from major trauma.

Malnutrition Universal Screening Tool (MUST)

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

Mental Capacity Act (MCA)

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

Methicillin-resistant Staphylococcus Aureus (MRSA)

A bacterium responsible for several difficult-to-treat infections in humans due to its resistance to methicillin and other beta-lactam antibiotics.

Monitor

The independent regulator of NHS foundation trusts.

MRI Magnetic Resonance Imaging.

Myocardial Infarction (MI)

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

Myocardial Ischemia National Audit Project (MINAP)

A national database gathering information on all patients who have had a heart attack or who have acute coronary syndromes.

National Early Warning Score (NEWS)

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

NHSLA Risk Management Standards for Ambulance Trusts

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

National Infarct Angioplasty Project (NIAP)

An audit of patients referred for an angioplasty surgical procedure.

National Institute for Health and Clinical Excellence (NICE)

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

National Learning Management System (NLMS)

Provides NHS staff with access to a wide range of national and local NHS eLearning courses, as well as access to an individual's full training history.

National Patient Safety Agency (NPSA)

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

National Reporting and Learning System (NRLS)

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

Net Promoter Score (NPS)

The net promoter score is a key measure of individual, team and corporate performance and is used to drive up positive patient experience.

NHS Commissioning Board

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

NHS Property Services (Prop Co)

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

Non-Executive Director (NED)

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

Part 4

OPD Out-patients Department.

OT Occupational Therapy.

Overview and Scrutiny Committee (OSC)

Local authority bodies that provide scrutiny of health provision in their local area.

PACS Picture Archiving and Communications System.

Paramedic

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

Paramedic Practitioner

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

Patient Administration System (PAS)

An information collection system that acute and community hospitals use to collect patient related data.

Patient Advice and Liaison Service (PALS)

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

Patient-Led Assessments of the Care Environment (PLACE)

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

Patient Report Form (PRF)

A comprehensive record of the care provided to patients.

Patient Transport Service (PTS)

A non-emergency medical transport service used, for example, to and from out-patient appointments.

PEAT Patient Environment Action Team

Personal Development Reviews (PDRs)

The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.

Personal Digital Assistants (PDAs)

Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.

PICU Paediatric Intensive Care Unit.

PGMC Post Graduate Medical Centre.

PPM Planned Preventative Maintenance.

PPU Private Patients Unit.

PRH Princess Royal Hospital.

Primary Care Trust (PCT)

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

Primary Percutaneous Coronary Intervention (pPCI)

A surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart. QGAF Quality Governance Assurance Framework.

Quality Innovation, Productivity and Prevention

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

RACH Royal Alexandra Children's Hospital.

Rapid Response Vehicle (RRV)

A car operated by the ambulance service to respond to medical emergencies either in addition to, or in place of, an ambulance capable of transporting patients.

Rapid Access Team (RAT)

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

RACOP Rapid Assessment Clinic for Older People.

Root Cause Analysis (RCA)

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

Safeguarding

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

Safety Thermometer

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

Serious Case Reviews (SCRs)

Establish whether there are any lessons to be learnt about the way in which staff and agencies work together to safeguard vulnerable people.

Serious Incidents (SIs)

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

SAU Surgical Assessment Unit.

Sexual Assault Referral Centre (SARC)

SARCs are specialist medical and forensic services for anyone who has been raped or sexually assaulted.

Part 4

Stakeholders

All those who may use the service, be affected by or who should be involved in its operation.

ST Elevation Myocardial Infarction (STEMI)

A type of heart attack.

Strategic Health Authority (SHA)

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

Serious Incident Requiring Investigation (SIRI)

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

Strategic Executive Information System (STEIS)

A system to collect data for the Department of Health.

SOP Standard Operating Procedure.

SSPAU Short Stay Paediatric Assessment Unit.

SystemOne

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

Trust Development Authority (TDA)

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

To Take Out (TTO)

'To take out' is the literal meaning for the medications patients take home.

Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE)

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

UCC Urgent Care Centre

Venous Thromboembolism (VTE)

A blood clot that forms within a vein.

Waterlow

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





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