Quality Account 2013-14

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Part 1

Introduction

Each and every one of the three quarters of a million patients we treat each year has a different set of clinical needs but what the word quality means in terms of their treatment and care is fundamentally the same for all of them. To demonstrate what we mean by quality we have organised this year's Quality Account into three sections: reducing avoidable harm; improving patient experience; and values and behaviours; and across the whole report and within each we have applied the approach we apply to everything we do: be positive and proud about the things we do well; open and honest about the things we need to do better; and clear about what we are doing about them. So, for example, the work we are doing to reduce the incidence of pressure damage (bed sores) and avoidable falls on our wards continues to have a positive impact and in the 2013-14 reporting year the rate of pressure damage acquired in our hospitals reduced by a further 21% and the rate of avoidable falls by a further 16% which means that over the last four years we have reduced the rates of pressure damage by 67% and our falls rates by a total of 44%.

One of our main challenges continues to be delivery of the four-hour A&E standard. Our year end position was 93% which is not good enough from anyone's perspective but particularly for the patients who are having to wait too long in our Emergency Department to be either admitted or treated and discharged. Although this challenge manifests itself in inconsistent achievement of the 4-hour standard, the issue is one of patient flow which encompasses the number and type of patients coming into our Emergency Departments; how quickly they are seen, treated and either discharged or admitted to an appropriate ward; and crucially, once they are medically fit, how quickly we can discharge patients either home or to an alternative care provider. In other words the impact on quality is more far-reaching than the Emergency Department itself. As with all of the areas where we have challenges and need to do better, we have in place comprehensive action plans which have delivered demonstrable improvement in many areas. But there is no silver bullet for fixing this and so we continue to work hard to make the improvements needed within the hospital and with our partners outside of the hospital to prevent patients coming in the first place and to ensure safe and timely discharge of patients who no longer need our care.

The other programme of work we have developed in 2013/14 to help address our challenges and make improvements where we know they are needed is Foundations for Success, a programme designed to shift our focus from short-term goals to long-term ambitions; and from reacting in the moment to investing in engagement/behaviours and delivery processes. The four priority areas within the programme are: values and behaviours; clinical strategy; clinical structure and empowerment, accountability and performance management. The output from each priority area overlaps and supports the other three and the individual and collective impact of them is a key part of our efforts to enhance the safety and quality of everything we do.

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

Matthew Kershaw
Chief Executive

Chief of Safety and Quality

The Quality Account is a report demonstrating the quality of our services. It details our achievements in the last year and outlines our plans to improve in the year ahead. The NHS is facing considerable challenges, not least delivering safer, higher quality care for less money. Brighton and Sussex University Hospitals faces some unique challenges but also has unique opportunities. The go ahead for the Teaching, Trauma and Tertiary Services (3Ts) programme is a fantastic opportunity not only to gain state-of-the-art buildings but also to re-energise our drive to improve the safety and quality of our services.

In preparing this report I have spent time talking to patients and their representatives. Their comments, feedback and stories have been central to the development of this report. Patients and carers using our services demand safe, high quality and compassionate care. In addition they demand a service that listens, learns and responds to their feedback. They want easy access to information about their healthcare, communicated in a way that they can understand.

In other words, if I am a patient requiring treatment at BSUH:

- How can I be sure I will be treated fairly, based on my needs and wishes as an individual and part of my community?
- How can I be sure the resources used to deliver my care are used wisely and not wasted?
- How can I be sure feedback on my experiences will be acted upon?
- How can I be sure I will be involved in making decisions that affect me?
- How can I be sure I will be treated with kindness and compassion?
- How can I be sure I am getting the right care for me, at the right time and by the right people?
- How can I be sure the care I receive will not harm me?

With the involvement of patients, carers and their representatives we will develop a new Safety and Quality Strategy for the Trust based around these seven questions. In this Quality Account we present some of the information that allows us to start answering these questions. It cannot cover all the projects and initiatives that our staff are committed to delivering but highlights our priorities.

Highlighting our achievements

In the last year our work on preventing patients falling, preventing skin damage due to pressure (‘bed sores’) and improving the safety of medicines have all reduced the risk of us harming patients. We ensure that we are delivering the best care by reviewing and implementing national guidance from the National Institute for Health and Clinical Excellence (NICE) within three months of publication. In addition patients have benefited from reduced hospital stays, reduced postoperative complications and a better outcome following surgery thanks to our Enhanced Recovery Programme. This programme is a method of ensuring all patients reliably receive care based on the best available evidence when they need an operation. These and many other achievements have contributed to the fact that the overall mortality rate for BSUH is consistently lower than that would be expected for the types of patients treated in our organisation.

Identifying our challenges and what we are going to do about them

For staff to deliver safe, high quality, compassionate care they need to feel respected, valued and empowered. Without this behaviour deteriorates, relationships become fractured and patients suffer. BSUH has some complex cultural and behavioural problems which have affected how we deliver care to patients. These are now being addressed through the Values and Behaviours programme. This project identified our shared values through consultation with staff, and implement new standards of behaviour which will deliver a safe culture. Our frontline staff routinely identify where things could be better. The 'Towards the Safer Hospital' project aims to harness this information and the enthusiasm of these staff to drive change from grassroots. The project aims to support frontline staff with expertise and access to senior members of the organisation to make changes happen. Communication has been highlighted by patients as a particular problem in BSUH. The ability to get information about appointments, to seek advice and responses to feedback (including complaints) have all been raised as areas where we need to improve. All of these areas will be reviewed and plans for improvement created in the coming year.

How will we achieve these improvements?

We have grouped the new and ongoing projects for the coming year into three categories which underline our priorities; Reducing Avoidable Harm, Improving Patient Experience, and Values and Behaviours. To be successful in these areas, and to achieve our aim of safe, high quality, compassionate care we need to deliver three things:

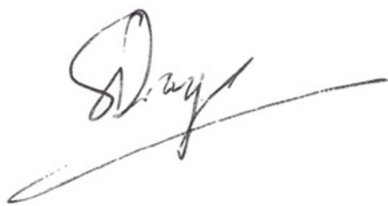
1) Culture: where it is everyone's responsibility to constantly seek to improve our performance and to identify and minimise risk. A culture of kindness, compassion and empathy.

2) Information for improvement: to measure our performance and use 'soft' intelligence (e.g. patient feedback) to understand what we do well and what we can improve.

3) Education and Innovation: to show people what good looks like and to be brave enough to do things differently in order to make things better.

By applying these three components to our priorities we can make real improvements to the standard of service we deliver.

In conclusion I hope you find this document a true reflection of the quality of our services and that it becomes a living document with which we can measure our progress against our stated priorities.



Dr Stephen Drage
Chief of Safety and Quality

Part 2

Our Safety and Quality Priorities

Reducing Avoidable Harm

- Reducing Avoidable Falls
- Reducing the risk of Venous Thromboembolism (VTE)
- Index of No Harm (Safety Thermometer)
- Follow-up of Investigation Results
- HIV Screening Programme in Emergency Medical Admissions
- National Institute for Health and Care Excellence (NICE)
- Reducing Harm from Medication (Medication Reconciliation)
- Improving the Prevention of Pressure Damage
- Reducing Hospital Acquired Infections
- Enhanced Recovery
- Intra-operative Fluid Management
- High Impact Innovations
- Nursing Standards
- Enhancing Quality
- Mortality
- Nutrition
- Patient Transfer
- Unscheduled Care
- Ward Round Checklist
- Towards the Safer Hospital
- Improving Communication with Primary Care
- Research and Education

Improving Patient Experience

- Patient Reported Outcome Measures (PROMs)
- Patients' Voice
- Quality Reviews
- Improving Care for Frailty Patients

Values and Behaviours

- Towards a More Engaged Workforce
- Values and Behaviours

The improvements sought in 2014/15 will be monitored by:

- Safety and Quality Committee
- Ward Working Wednesday (weekly senior nursing forum)
- Research and Development Committee
- Operational Management Team
- Infection Prevention and Control Action Group
- Patient Experience Forum
- Board Quality and Risk Committee

Reducing Avoidable Harm

Reducing Avoidable Falls

Why?	Inpatient falls in hospital are a ubiquitous problem throughout healthcare and a significant source of increased length of stay, excess morbidity and avoidable mortality every year within Brighton and Sussex University Hospitals NHS 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.
Last year's target	**Achieved:** A target of no more than 4.1 falls per 1,000 bed days was set for 2013/14. This target equated to a 10% reduction in the falls rate. The falls rate for 2013 was 3.47 per 1,000 bed days which is equivalent to a 16% reduction.
Improvements delivered in 2013/14	This initiative has focussed on the theory that falls are a behavioural, rather than a systems, problem. The approach for this initiative has been to focus on the behaviour of the individuals caring for the patient in the belief that if their actions are fall-safe it has the potential to spread through imitation to other members of staff. This innovative approach has resulted in the Care Quality Commission advising other Trusts to contact BSUH for advice on falls prevention and during the past year the team has hosted a number of other Trusts and provided teaching both here in the UK and Gibraltar. • Since 2009/10 the falls rate has come down by 45%; this equates to over 600 fewer falls per annum. • Two wards in the Trust, Baily Ward and Bristol Ward, have recorded exceptionally low rates of just over 1 fall per 1,000 bed stay days. During the last year these two wards reported only 15 falls between them, this compares to the 105 falls reported in 2009/10. • The falls project lead has been working collaboratively with the Trust partners in the community.
2014/15 goal(s)	The target for this year is to reduce the falls rate by a further 10%, this would mean bringing the rate down to 3.12 falls per 1,000 bed stay days.

Reducing the Risk of Venous Thromboembolism (VTE)

Why?	VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated by a Health Committee Report in 2005 that there were around 25,000 deaths from VTE each year in hospitals in England and many of these were avoidable.
Last year's target	**Achieved:** The target of 95% of patients having a VTE risk assessment was achieved. The rate for 2013/14 was over 95% every month. **Partially Achieved:** The target of undertaking a root cause analysis of all hospital associated VTE was renegotiated for the local CQUIN to 60%. This target of 60% has been met. **Not Achieved:** The plan for undertaking a routine audit of case notes for compliance with VTE guidance is still being finalised.
Improvements delivered in 2013/14	A process has been set up for identifying patients who require a root cause analysis and notifying the Thrombosis Nurses who then perform a review of the patient's notes. Cases are presented and discussed at the Thrombosis Committee for action and feedback. An online tool for capturing audit and root cause analysis data relating to Venous Thromboembolism events has been developed, rolled out and reporting has started.
Ongoing monitoring	This initiative is now embedded and will continue to be monitored for the Board Scorecard.

Index of No Harm (NHS Safety Thermometer)

Why?	The NHS Safety Thermometer is a national tool that has been designed to be used by clinicians to measure the level of harm caused to patients by pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. It is undertaken monthly and includes all adult patients in the Trust.
Last year's target	A national target for the safety thermometer was not set this year. Originally it was expected that pressure damage would be the focus for a reduction in avoidable harm. Although no target was set, the Trust has been running a pressure damage initiative. This initiative, discussed in more detail later in this section, has delivered a 20% reduction in the rate of pressure damage.
Improvements delivered in 2013/14	The data captured by the safety thermometer has now been incorporated into the monthly ward reports produced for ward managers and their staff. The medical notes of 9,070 patients have been screened during 2013/14 using the safety thermometer tool. 93.6% of the Trusts patients were harm free. This compares to a national average of 93.1% of patients being harm free.
Ongoing monitoring	This initiative is now embedded and will continue to be monitored through the Trust safety and quality Scorecard.

Follow-up of Investigation Results

Why?	The results of any investigation requested in hospital should be reviewed to ensure that the patient is being appropriately managed and all available information is known to the clinicians caring for that patient.
Last year's target	**Achieved:** The existing safety nets have been improved resulting in a reduction in the number of investigation results in Imaging and the Emergency Department that are not reviewed by a clinician. Work is continuing in the development of Order Comms which will provide an electronic solution to the follow up of investigation results.
Improvements delivered in 2013/14	A system for the follow up of urgent, critical and unsuspected findings has been developed for the Emergency Department (ED). All these results are followed up on a daily basis by either a doctor in the ED (for patients discharged from ED) or the Safety and Quality Team (for those patients who are admitted). In addition a report has now been developed for the ED of all images requested in the previous 24 hours and these are reviewed each morning by a junior doctor and images followed up as appropriate.
2014/15 goal(s)	This initiative is now embedded and will be reported to the Executive Safety and Quality committee by exception.

HIV Screening Programme in Emergency Medical Admissions

Why?	Early diagnosis of HIV offers significant health benefits for the individual and for public health. Prevalence of HIV in our local community is four times over the threshold at which opt-out testing is deemed to be cost effective. UK Department of Health guidelines suggest all medical admissions where prevalence exceeds 2/1,000 should have a routine HIV test. Routine HIV testing has been shown to be cost effective due to high costs of late diagnosis where diagnosed local prevalence exceeds 2/1,000. Brighton & Hove prevalence is 7.16/1,000
Last year's target	**Achieved:** The target was to offer HIV Testing to over 65% of Emergency Medical Admissions. During 2013/14 the test was offered to 69% of Emergency Medical Admissions. Of this population of 2,838 patients, 3 new HIV diagnoses were made.
Improvements delivered in 2013/14	The HIV screening programme employed a band 3 Healthcare Assistant on a 1.0 whole time basis who provided 5 days cover in obtaining consent from all eligible Emergency Medical Admissions patients at RSCH HIV screening. A Band 7 Health Adviser provided cover for the project for an additional day, thus maximising opportunities to obtain consent for HIV testing from patients. Of the 69% of patients (2,838) who were offered HIV testing 98% (2,786) said yes.
2014/15 goal(s)	This initiative will continue to offer testing to over 65% of all Emergency Medical Admissions, ensuring that over 95% of patients give consent to HIV testing. The project will be reported to the Executive Safety and Quality committee by exception.

National Institute for Health and Care Excellence (NICE)

Why?	The implementation of NICE guidance supports consistent improvements in people's health and equal access to healthcare across the country and the local health economy by creating standards of care based on the best available evidence.
Last year's target	**Partially Achieved:** 100% of NICE technology appraisal guidance to be reviewed and implemented within 90 days. Whilst we achieved the target for 114 of the NICE publications, at year end we have two NICE Technology Appraisals Guidelines currently awaiting sign off due to their complexity.
Improvements delivered in 2013/14	In order to facilitate quicker discussions for sign off we have implemented a robust process and reporting system set up through the Drugs and Therapeutics Committee whereby all NICE Technology Appraisals Guidelines are presented by the lead clinician, discussed and signed off. The report produced for the in-house Drugs and Therapeutics Committee is also distributed to our local commissioners to ensure they are informed of drug changes / payment increases and can advise primary care to ensure that patients receive appropriate treatment according to NICE in all healthcare settings.
2014/15 goal(s)	This initiative is now embedded and will continue to be monitored for the Trust via the Safety and Quality Scorecard and by exception via the monthly Divisional reports to the Safety and Quality Committee.

Reducing Harm from Medication (Medication Reconciliation)

Why?	As NICE have evidenced, medication errors occur most commonly during transfers between care settings and particularly at the time of admission. NICE cite two literature reviews which reported unintentional variances of 30-70% between the medications patients were taking before admission and their prescriptions on 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.
Last year's target	**Not Achieved:** A target of 90% of patients having medication reconciliation within 24 hours of admission to hospital was set for this year. Since April 2013 the medicines reconciliation rate has improved from 70% up to 86%. Although our target was not achieved, this figure compares favourably with other Trusts from around the country.
Improvements delivered in 2013/14	The pharmacy department have developed an audit process to monitor monthly rates of medication reconciliation within 24 hours of admission. An audit takes place on a monthly basis to measure medication reconciliation rates across every ward. The results are shared regionally to provide beneficial benchmarking with other local Trusts. The development of a 7 day pharmacy service to the admission wards together with e-prescribing will be instrumental in helping reach the 90% target.
2014/15 goal(s)	To ensure that 90% of patients have medication reconciliation within 24 hours of admission to hospital.

Improving the Prevention of Pressure Damage

Why?	There is clear evidence that pressure ulcers have multiple negative effects on a patient's wellbeing. Pain, discomfort, depression, social isolation, prolonged hospital stays, increased morbidity and mortality risks are all well documented.
Last year's target	**Achieved:** A target of a 10% reduction in grade 2 pressure ulcers was set for 2013/14. A 21% reduction in grade 2 pressure damage was achieved. **Partially Achieved:** The target of no avoidable grade 3/4 pressure ulcers was not met. However, a 23% reduction in grade 3/4 pressure ulcers was delivered. Out of the 17 grade 3 and above pressure ulcers investigated in the last year 10 were found to be avoidable.
Improvements delivered in 2013/14	For all grades of pressure damage the overall reduction is 21.3%. Working closely with our local CCG a more robust reporting process has been implemented along with a more rigorous investigation procedure which is led by the BSUH Wound Care Team. This has ensured that lessons are learnt and improvements in practice can be shared directly with ward staff. This process also ensures that the patients are kept fully informed of when and how pressure ulcers develop.
2014/15 goal(s)	Over the last 4 years the pressure damage rate has come down by 67%. The goal for 2014/15 is a 10% reduction in grade 2 pressure damage and no avoidable grade 3/4 pressure damage.

Reducing Hospital Acquired Infections

Why?	Infection prevention and control is vital in ensuring patient safety, preventing harm, delivering good outcomes, maintaining the Trust's reputation and the public's confidence. Over recent years BSUH have made great reductions in the rates of hospital acquired infections and this work will continue over the coming years.
Last year's target	**Not Achieved:** The Trust target was to have no more than 34 hospital acquired cases of Clostridium difficile and zero avoidable MRSA bacteraemias. During 2013/14 we have had 48 hospital acquired cases of Clostridium difficile and two MRSA bacteraemias that were potentially avoidable.
Improvements delivered in 2013/14	Overall we had a year on year reduction in Clostridium difficile (52 cases occurred in 2012/13). The focus this year has been on isolating patients based on symptoms rather than waiting for microbiology results. The Trust has been focussing its improvement efforts on five areas identified by the Trust Development Authority: Mandatory IPC training; Prompt isolation of patients with infective diarrhoea; Appropriate stool samples; Appropriate antibiotic prescribing; Cleaning.
2014/15 goal(s)	Infection control targets are set nationally. The reduction target goal for 2014/15 is zero avoidable MRSA bacteraemias and no more than 50 Trust acquired cases of Clostridium difficile (Note: The nationally set target for the number of hospital acquired Clostridium difficile cases is higher than the target that was set in 2013/14).

Enhanced Recovery

Why?	The Enhanced Recovery Programme (ERP) is about improving patient outcomes and speeding up a patient's recovery after surgery. It results in benefits to both patients and staff. The programme focuses on making sure that patients are active participants in their own recovery process. It also aims to ensure that 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.
Last year's target	**Achieved:** Last year's target was to increase the number of patients enrolled on the Enhanced Recovery pathways, to continue with the reporting and improvement of patient outcomes and increase data collection submissions (85% data completeness target). These have all been achieved.
Improvements delivered in 2013/14	All pathways are fully established and processes are now in place to capture and enter the data relating to the ERP measures. All pathways are achieving above the target set by the local CQUIN and all patients appropriate for Enhanced Recovery are following the pathways. Each pathway now has their own in-house ERP meetings where compliance with the clinical measures, progress against the targets and plans for improvement are discussed. We now have an Enhanced Recovery Nurse Lead who is currently developing an internal website for staff and an external facing page for patients. In addition we have quarterly in-house meetings where all pathway leads come together to discuss progress, share learning and plan next steps.
2014/15 goal(s)	Specific targets for this initiative are only set after a review of the previous year's baseline data. This process was still ongoing at the time of publication. However, our goal will be to continue to improve performance against targets by ensuring that all patients get all measures 'every patient, every time' and meet the targets outlined for Kent, Surrey and Sussex in line with the local CQUIN agreement. To continue to improve patient information and awareness through the development of an external facing webpage and short film on what to expect during their recovery period after surgery.

Intra-operative Fluid Management

Why?	Maintaining optimal fluid status during and immediately after surgery is a vital component of high quality surgical care and can contribute to achieving enhanced recovery.
Last year's target	**Achieved:** The target was to develop ways to collect data on Intra-operative Fluid Management in all relevant specialties in line with the targets set by the national CQUIN.
Improvements delivered in 2013/14	A process has been set up for identifying the numerator and denominator to calculate the use of Intra-operative Fluid Management within BSUH. The numerator is generated by identifying patients coded as having one of the procedures recommended for Intra-operative Fluid Management by the National Technology Adoption Centre. The denominator is then identified by extracting a list of patients from the Deltex machines for fluid management used in theatres. The Trust has one of the highest uses of Intra-operative Fluid Management in the region.
Ongoing monitoring	This programme is now complete

High Impact Innovations

Why?	The High Impact Innovation programme has been developed to support the spread and diffusion of significant innovation more widely across the NHS.
Last year's target	**Achieved:** The target was to develop clear plans within the region to deliver on high impact innovations relevant to the Trust. This included a focus on Intra-operative Fluid Management (see separate project) as well as embedding new projects focusing on telehealth and telemedicine. This was achieved as below.
Improvements delivered in 2013/14	Digital First, our HIV service at BSUH, is now running an email service for stable patients living with HIV. Instead of being seen two or three times a year by a physician, patients are now seen once a year and interim results are emailed to patients with medication dispensed by a home delivery company. We currently have 650 patients registered with the email service (30% of the current HIV cohort), saving up to 1,000 face-to-face appointments per year. This patient-centred approach helps to reduce the impact of healthcare on patients living with a chronic illness and helps the department to manage capacity in the context of an increasing cohort (7% per annum) and a resource-constrained NHS.
Ongoing monitoring	This programme is now complete.

Nursing Standards

Why?	Measuring and reviewing the quality of nursing documentation has been used as a proxy measure for assessing the quality of nursing care. The nursing metrics and the ward based reports are being routinely used to provide assurance that inpatient areas are providing high quality and safe care.
Last year's target	**Achieved:** The target last year was to embed the monthly ward reports within the Trust governance structure and use the reports proactively to address safety and quality issues. This has been achieved as per below.
Improvements delivered in 2013/14	We have audited over 10,000 sets of notes since this initiative began, this is approximately 13% of all inpatient admissions. The audit tool has been reviewed to focus on the accuracy of documentation. The information collected is now being triangulated with other data such as patient feedback, pressure damage and falls. The information collated by this initiative is now being disseminated widely forming the basis for ward quality and safety posters for patients along with summary reports for all staff who work in clinical areas.
Ongoing monitoring	This initiative is now embedded and will continue to be monitored for the Board Scorecard.

Enhancing Quality

Why?	Enhancing Quality is a clinician-led quality improvement programme launched in January 2010 across Kent, Surrey and Sussex encompassing 10 Acute Trusts, 6 Community Providers and 3 Mental Health Trusts. Enhancing Quality aims to improve patient outcomes and reduce variation in care.
Last year's target	**Achieved:** We have achieved the target of 95% data completeness consistently throughout the year. **Achieved:** We have set a benchmark with targets for Appropriate Care Scores. We have performed above the improvement target for appropriate care scores for the Pneumonia Pathway. **Partially Achieved:** We have not achieved the improvement target set for appropriate care scores for the Heart Failure pathway.
Improvements delivered in 2013/14	We have achieved greater clinical engagement with leads for both pathways. In-house reports are produced and shared with wider clinical teams which has helped raised awareness of this initiative and its benefits for patients.
2014/15 goal(s)	As discussed in the goal for the Enhanced Recovery initiative, specific targets for this year's project are currently being calculated. However, our goal is to continue to improve performance against targets by ensuring that all patients get all measures 'every patient, every time' and meet the targets outlined for Kent, Surrey and Sussex in line with the local CQUIN agreement.

Mortality

Why?	Mortality data is a key indicator of the quality and safety of the services provided by a hospital.
Last year's target	**Achieved:** The target was to be in the expected or better than expected range for Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). As of April 2014, the Trust's HSMR was within the expected range at 96.95 whilst the SHMI was better than expected at 91.04 (lower confidence limit 86.5, upper confidence limit 95.8)
Improvements delivered in 2013/14	The Trust Level Mortality Review group has been reinvigorated. The multidisciplinary group are meeting bi-weekly to review mortality statistics (HSMR and SHMI) at the level of specialty, diagnostic group and operation group level. The group also oversee mortality alerts generated via the Care Quality Commission indicator list and other nationally published mortality indicators. Individual specialities are asked to investigate specific alerts and present their findings, together with any lessons learned back to the group.
2014/15 goal(s)	To implement a standard process for mortality review across the Trust

Nutrition

Why?	Preventing, recognising and treating malnutrition is essential to the recovery and well-being of all our patients.
Last year's target	**Not Achieved:** The target was to continue to improve nutrition screening and treatment rates aiming for 98% compliance with Malnutrition Universal Screening Tool (MUST). In 90.5% of the notes reviewed the patient had received a full nutritional review using the MUST score.
Improvements delivered in 2013/14	A new training package has been developed for nurses and HCAS on the Preceptorship programme. There is a new and improved rolling programme of training for more experienced nurses across BSUH.
Ongoing monitoring	Compliance with the MUST score will continue to be monitored as part of the routine review of the ward metric reports.

Patient Transfer

Why?	At any point where there is a hand-over 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.
Last year's target	**Not Achieved:** The target to have accurate data regarding the time of patient transfers has been challenging and work is still ongoing to complete this analysis. Work has been completed analysing the frequency of patient moves. In addition, routine reports have been set up to enable the Patient Transfer group to identify themes from patient safety incidents relating to transfers.
Improvements delivered in 2013/14	The profile of patient transfer and safety in the Trust has been raised by the Transfer group. This project will also gain extra momentum as it has been identified as a local CQUIN project for 2014-15.
2014/15 goal(s)	1) To undertake a series of case note reviews for patients with multiple transfers. 2) To develop a package of care to improve the quality of transfers within the hospital. As part of this package a range of quality metrics will be identified. 3) To identify themes and develop strategies for reducing unnecessary transfers. 4) To implement a 'safer transfer' care bundle.

Unscheduled Care

Why?	Patients should be assessed and transferred to an appropriate care environment within 4 hours of being in the Emergency Department (ED).
Last year's target	Last year's target was to improve patient flow within the hospital and reduce length of stay within the ED. **Not Achieved:** Overall performance against the 4 hour standard was not improved during 2013/14. **Achieved:** The target to eliminate 12 hour breaches within the Emergency Department was achieved in 2013/14.
Improvements delivered in 2013/14	Quality and safety in the Emergency Department has improved by provision of extra staff and improved working practices.
Ongoing monitoring	Achieving the 4 hour standard will not be a Quality Account Priority in 2014/15. However, this target will continue to be monitored via the Trust Scorecard.

Ward Round Checklist

Why?	Using a Ward Round Checklist can improve communication and the effectiveness of ward rounds. The checklist prompts clinical teams to consider basic issues of care which, though familiar, are sometimes missed or forgotten, potentially causing harm or distress to patients. Improving ward round efficiency will benefit patient safety and patient flow. This work will be in carried out in close collaboration with the non-consultant network to provide grassroots intelligence.
Last year's target	**Achieved:** To further explore the organisational aspects of the ward round.
Improvements delivered in 2013/14	A detailed evaluation of a systematic approach to ward rounds incorporating briefings, debriefing, checklists and a focus on prioritising tasks was carried out on 2 wards. The wards implementing the changes saw the following improvements: 1) Reduced length of stay 2) Fewer MET calls/outreach interventions, and 3) Improved Friends and Family Test scores
2014/15 goal(s)	This project will be re-titled Towards a Safer Ward and will focus on delivering a sustainable improvement project around ward round performance to other wards.

Towards the Safer Hospital

Why?	**New Initiative** 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'.
The projects include:	• Towards a safer ward: improving ward round processes to ensure safe care • Towards a safer transfer: improving the quality and reducing the frequency of patient moves around the hospital • Towards a safer handover: improving the quality of handover between departments by the development of checklists and electronic solutions • Towards a safer operating theatre: developing safety culture in the operating theatre • Towards a safer emergency department: use of checklists and prompts to increase consistency of care in the Emergency Department.
How will we monitor success?	• Reduction in length of stay • Reduction in medical emergency and cardiac arrest calls • Improved patient experience measured by Friends and Family Test scores • Development of a data visualisation tool to display complex information in a meaningful format • Reducing the number of transfers per patient

Improving Communication with Primary Care

Why?	Effective communication with primary care is fundamental in ensuring the continuity of care for patients discharged from hospital.
Last year's target	**Not Achieved:** The Trust is not currently sending automated letters to GPs as had been the aim for 2013/14.
Improvements delivered in 2013/14	Work has been ongoing with the Outpatient Booking Hub to agree the roll out schedule and system supplier. This should be completed by December 2014.
Ongoing monitoring	The work is ongoing and will be monitored via the Hospital Management Board.

Research and Education

Why?	As a teaching hospital the Trust needs to develop its reputation as an academic centre for education and research and to improve patient care through increasing participation in clinical trials.
Last year's target	**Achieved:** The target for last year was to increase the number of new trials opened. During the past 12 month the Trust increased the number of trials it opened by 20%.
Improvements delivered in 2013/14	There were 156 new portfolio studies opened to patients.
Ongoing monitoring	This initiative is now embedded and will continue to be monitored by the Research and Development governance structures.

Improving Patient Experience

Patient Reported Outcome Measures (PROMs)

Why?	When used alongside clinical outcomes, PROMS are a key tool to measure the effectiveness of care by capturing and reviewing health benefits before and after surgery as perceived by patients themselves. Four common elective surgical procedures are included in the national PROMs programme. These are: groin hernia operations; hip replacements; knee replacements; and varicose vein procedures.
Last year's target	**Achieved:** The target set for 2013/14 was to be above the national average regarding participation rates for PROMS procedures. In February 2014, the overall participation rate for BSUH was 73.9% which is slightly above the national average participation rate of 72.7%.
Improvements delivered in 2013/14	This year's efforts have focussed primarily on improving our participation rates so that we have the largest possible pool of data from which the outcome measures can be calculated, making those measures, in turn, more meaningful. Training has been provided to nursing staff in the pre-operative assessment clinics so that they fully understand the requirements of the PROMs programme and their roles within it. A system for providing regular feedback to clinic managers is in place so that they can see how their particular clinic is performing on a monthly basis, rather than waiting for the quarterly published data to be made available. Exploratory, but detailed, analysis of the orthopaedic outcomes data has been commenced, with a commitment to expanding this further and to replicating it for groin hernia and varicose vein procedures. The rationale for doing this is to understand what factors at BSUH may be influencing the different components of each measure in order to identify the actions required to improve future outcomes.
Ongoing monitoring	This initiative is now embedded and will continue to be monitored via the Safety and Quality Committee Scorecard.

Communicating and Learning from Patients: Patients' Voice

Why?	The views of patients are an important measure in assessing the quality of care provided by staff. The Trusts Patient Voice Survey, the National Patient Satisfaction Surveys (A&E, Inpatients 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 monthly Patient Experience Panel. This gives us the opportunity to obtain our patient's views not only on the services we provide but also invites their input into service developments and improvements. For inpatients the Patient Voice survey has been adapted to incorporate the national Friends and Family test. The Friends and Family Question of whether you (the patient) would recommend this hospital to a relative or friend is also asked in A&E and will be extended to outpatients during 2014-15. Our complaints and PALS teams work closely together to identify emerging themes from the informal and formal concerns received. The teams work closely with the specialties to ensure that lessons are quickly learnt from any reported poor patient experience.
Last year's target	**Partially Achieved:** Last year's target was to survey 15% of inpatients. Over 5,000 inpatients completed the patient voice questionnaire during 2013 – 14, this equates to 17.6% of the inpatient population. **Not Achieved:** We failed to meet the 15% target in the Trusts three Accident and Emergency departments; although over 9,000 patients were surveyed the total response rate was just over 10%.
Improvements delivered in 2013/14	The response rate has improved over the course of the year. The information captured by the patient voice surveys is now being fed back to patients via the ward posters which include an update for patients on what we have done from their suggestions - "you said, we did". Responses from the questionnaires are included in the monthly ward reports for ward managers and in the staff quality and safety hand-outs that are produced for each ward. Action plans from the NPS will be reported to, and monitored by, the Divisional Quality and Safety Committees Patient Experience Panel. A key area emerging from the 2012 NPS was the need for better information about ward routines. Significant work has been undertaken to improve patient information regarding safety and quality indicators, nursing roles and numbers on the ward and visual identification of ward managers, matrons and consultants working on all wards. Medication on hospital discharge was also highlighted to need improvement and the chief pharmacist met regularly with the Patient Experience Panel and recruited a patient representative to the Trust working group.
2014/15 goal(s)	To meet the national response rate targets for A&E, inpatients and outpatients. To improve on this year's inpatient score of 65 for Friends and Family Test and to increase the A&E score from 31. To produce patient posters every two month with feedback on what we are doing with the comments made by patients. Clinical staff's engagement with complaints to be linked to performance management. Develop a systematic approach to capturing learning from complaints. Devise a fair and systematic approach to selecting patient stories to ensure they are representative of complaints received. Action plans arising from national patient surveys to be reported to and monitored by the Patient Experience Panel.

Quality Reviews

Why?	New Initiative Quality reviews, 'Sit and See', are used as a form of peer review whereby multidisciplinary teams visit areas using the framework around quality of care, kindness and compassion. This involves talking to patients and staff about their experiences in the hospital and observing the delivery of care. Feedback will be given to teams on areas of good practice and areas for improvement. It will also be used to share best practice across the organisation.
2014/15 goal(s)	A programme of multidisciplinary quality reviews will be undertaken on a monthly basis.

Improving Care for Frailty Patients

Why?	New Initiative The care of frail, usually elderly patients is a core part of the Trust Clinical Strategy. Recent national reports including the Francis Inquiry have all been critical of the care delivered to our frail and elderly patients. 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 for frail and elderly patients. This initiative is aimed at developing a whole system pathway for frail patients.
2014/15 goal(s)	1) Define frailty in the Emergency Department in order to identify patients that would be considered for the frailty pathway and receive comprehensive geriatric assessment. 2) Ensure all patients who meet the criteria for the frailty pathway are entered into FRAILsafe. 3) Develop the case for a fully funded 'Frailty Team' 4) Develop robust measurement around frailty.

Values and Behaviours

Towards a More Engaged Workforce

Why?	**New Initiative** 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 BSUH Innovation Forum (IF) was launched as a means of encouraging and enabling grassroots innovation. IF is a platform where anyone and everyone working at BSUH 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.
Improvements delivered in 2013/14	Since the launch, IF has seen 19 projects presented at seven events, which are held every quarter. For this success to continue, we need to expand further, and reach new staff in new areas, engaging all staff groups throughout the Trust. We have noted that our most successful projects have been those involving multidisciplinary collaboration, such as the BSUH Falls Proforma in which IF linked three Foundation Year 2 doctors with the Safety and Quality Team already known for their work in reducing inpatient falls.
2014/15 goal(s)	We hope to build on our successes, support more projects, and expand to the wider workforce, in order to give everyone the chance to have their say and improve their ward, department, or service.

Values and Behaviours

Why?	New Initiative As part of the wider Foundations for Success project, with its key objective of providing safe, effective and efficient care to patients, the Value and Behaviours project was launched to staff in January 2014. It is about understanding that organisational culture affects employees, patients, relatives, carers and impacts on the general operation of the Trust.
2014/15 goal(s)	To embed the new Values and Behaviours blueprint, which was launched in May 2014, in the way that all staff behave at work and alongside this deliver the implementation plan that will enable staff to do this. The implementation plan will focus on the following areas: Communicating and Engaging; Learning and Innovating; Empowerment; Accountability and Performance; Leadership and Team Work; Practical Process; Race Equality and Intolerance of Prejudice.

Part 3

Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income (2.5% - £6.3m) in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Brighton and Hove CCG and the Trust through the Commissioning for Quality and Innovation (CQUIN) payment framework. The table below illustrates that the Trust delivered on all but two of this year's CQUINs receiving a payment of £6.1m.

National CQUINS	
Friends and Family Test	Partially Achieved
NHS Safety Thermometer - Data collection	Achieved
Dementia	Achieved
VTE	Achieved
High Impact Innovation	
3 million lives	Achieved
Inter-operative Fluid Management	Achieved
Digital First	Achieved
Dementia	Partially Achieved
Local/Regional CQUINS	
Enhancing Quality - Heart Failure Improvement	Achieved
Enhancing Quality - Pneumonia Improvement	Achieved
Enhancing Quality - Antipsychotic prescribing	Achieved
Enhanced Recovery Programme - Colorectal	Achieved
Enhanced Recovery Programme - Gynaecology	Achieved
Enhanced Recovery Programme - Hip and Knee	Achieved
Heart Failure readmissions	Achieved
COPD pathway development	Achieved
EQ/ERP peer review	Achieved
EQ/ERP engagement	Achieved
EQ/ERP Patient experience engagement	Achieved
Local patient experience	Achieved

Local/Regional CQUINS	
Smoking Cessation	Achieved
Shared Decision Making - Hips and Knees	Achieved
Shared Decision Making - Patient recollection	Achieved
Medication Discharge Advice	Achieved
COPD care bundle project	Partially Achieved
Urgent Care	Partially Achieved
Specialised Services CQUINS	
Cardiac Surgery Inpatients	Achieved
Neurosurgical Shunts	Achieved
HIV/GP registration and communication	Achieved
Major Trauma	Achieved
Neonatal care - Improved access to breast milk	Achieved
Neonatal care - Timely admin of TPN	Achieved
Neonatal care - Timely simple discharge	Achieved
Neonatal care - Retinopathy screening	Achieved
Radiotherapy access	Partially Achieved
Renal Medicine - renal patient view	Achieved
Renal Medicine - AKI	Partially Achieved
Specialist Cancer Nurse	Achieved
Highly Specialised Services	Achieved
Dashboard CQUINS	
NICU dashboard	Achieved
PET CT dashboard	Achieved
Renal dialysis dashboard	Achieved
Radiotherapy dashboard	Achieved
HIV dashboard	Achieved
Cardiac dashboard	Achieved

National Clinical Audit

During 2013/14 BSUH participated fully in 33 (89%) of this year's 37 national clinical audits. We participated in all of the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) in which we were eligible to participate. The national clinical audits and NCEPOD that BSUH participated in during 2013/14 are set out 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 and enquiry, and where appropriate, the actions taken to improve the quality of healthcare provided.

Audits	Eligible	Participation	% of cases submitted to each	Action to improve quality of healthcare
Case Mix Programme (CMP)	Yes	Partly (PRH only)	100% (PRH)	The Princess Royal Hospital site participates fully in the Case Mix Programme (CMP) and reports are circulated regularly to the critical care team. The Royal Sussex County Hospital does not presently participate in the CMP, due to the lack of a compatible clinical information system. However, there is work in progress to ensure this is resolved in the very near future.
National Audit of Seizures in Hospitals (NASH)	Yes	Yes	100%	The team is currently piloting a new first seizure proforma and is about to re-audit the impact of this on the quality of referral and investigations on first seizure patients.
National emergency laparotomy audit (NELA)	Yes	Yes	n/a	This new national audit is still in its early stages, currently only about a quarter of the way through the first period of data collection. The first report, covering organisational audit information only is scheduled for May 2014, whilst the first report on clinical data is scheduled for publication in July 2015.
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	100%	Cases are reviewed bi-monthly at the morbidity and mortality meetings. Clinical team reviews are also undertaken and the service is scrutinised at local level via the Trauma Committee and at regional level via the Operative Delivery Network.

Audits	Eligible	Participation	% of cases submitted to each	Action to improve quality of healthcare
National Joint Registry (NJR)	Yes	Yes	100% at PRH and SOTC. <100% at RSCH.	We have changed our implants to 2 out of the top performing 3 implants for hips. We are also encouraging the super-specialization of surgeons. It was traditional for surgeons to perform hip and knee replacements - both primary and revision. Surgeons now only perform operations that they do regularly. This means that limitations have been placed on all surgeons' practice, limiting them to their strengths. Revisions are now only performed by revision specialists. To improve data submission rates for non-elective cases (RSCH) clearer processes have been established with theatre teams to ensure NJR forms are completed. There is now also an audit officer in post tasked with collecting the data.
Bowel cancer (NBOCAP)	Yes	Yes	>100%	The multidisciplinary team carry out a number of additional audits in conjunction with the NBOCAP e.g. rectal cancer oncological outcomes are audited annually. The latest of these audits has shown excellent (low) rates of positive margins.
Lung cancer (NLCA)	Yes	Yes	c. 100%	The multidisciplinary team has concentrated on improving the tissue diagnsotic rate, seeing a Macmillam Nurse and treating small cell with chemotherapy as well as resection rate. Significant improvement has been seen on all of these over the last 5 years. Other achievements include securing the tender for endobronchial ultrasound services for patients across Sussex. This commenced in March 2014 and will provide swift access to the diagnostic test that patients previously would have had to travel to Guys and St Thomas' Hospital for.
Head and neck oncology (DAHNO)	Yes	Yes	c. 100%	The multidisciplinary team, with help from the Macmillan organisation, has established a support group for head and neck cancer patients which has been well attended. A DVD to help communication with laryngectomy patients has been very well received. CD recordings of "significant consultations" continue to be offered to patients in the clinic.

Audits	Eligible	Participation	% of cases submitted to each	Action to improve quality of healthcare
Oesophago-gastric cancer (NAOGC)	Yes	Yes	c. 100%	Development of guidelines on the common acute oncology upper gastro-intestinal presentations has been undertaken, such as ascites, dysphagia, and haematemesis. The majority of members of the multidisciplinary team have completed an Advanced Communications Skills course.
National Vascular Registry	Yes	Yes	100%	The Trust continues to submit data to high level of completeness.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100%	The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.
Cardiac Rhythm Management (CRM)	Yes	Yes	100%	The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.
Coronary angioplasty	Yes	Yes	100%	The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.
National Adult Cardiac Surgery Audit	Yes	Yes	100%	The outcomes data are presented on a monthly basis within the Cardiac Surgery Clinical Governance and Management meetings, and the department has evolved a process to look at outcomes other than death to improve patients care.
National Cardiac Arrest Audit (NCAA)	Yes	No	n/a	Participation in this national audit requires the Trust to pay to subscribe to the NCAA. After exploring the option, the Resuscitation Operational Management Group decided not to subscribe as it is costly with no real benefit to the Trust. Instead, BSUH has, for a number of years now, carried out local audit of cardiac arrest data that is actually more comprehensive than the national audit and therefore more valuable. Results of the local audit are consistently very good and are a reflection of the resuscitation service being firmly rooted in recognition and management of the deteriorating patient before they arrest.

Audits	Eligible	Participation	% of cases submitted to each	Action to improve quality of healthcare
National Heart Failure Audit	Yes	Yes	100%	The Cardiac Department has a well established programme of participation in national audits. Results are used to provide a starting point for relevant local audits.
National Comparative Audit of Blood Transfusion programme	Yes	No	n/a	The Trust did not participate in the comparative audits during 2013/14 due to the commitment required for implementing the new Bloodhound Traceability system (an electronic system for printing and scanning blood sample labels which allows all blood products to be tracked with correct patient details). The Trust has now successfully appointed a second Transfusion Practitioner, which will enable BSUH to take part in future national Comparative Audits.
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	100% (NADIA); 56% NDA)	Low participation in the NDA is due to a number of cases not meeting the minimum dataset required. Two reasons for this have been identified; incomplete recording of correct NHS number, and incomplete recording of date of diagnosis. The former has already been addressed for future audits through linking the local clinical information system with the main Trust Patient Administration System. Clinicians are also being reminded about their responsibility to record date of diagnosis in all cases.
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	Since the previous year, we have improved the clinic templates, put more patients on insulin pumps and the average HBA1c has shown a further improvement from previous year.
Inflammatory bowel disease (IBD)	Yes	Yes	100%	The team has an ongoing action plan to continue to improve services, using the IBD audit standards as a benchmark. A significant devlopment within this, plans for which are currently well underway, is the establishment of an IBD super-clinic which will have all members of the multidisciplinary team together in one clinic. This clinic is expected to improve patient experience of the clinics considerably. The team is also planning to appoint a second IBD nurse and a second IBD surgeon in the near future.

Audits	Eligible	Participation	% of cases submitted to each	Action to improve quality of healthcare
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes	n/a	Data collection is ongoing at time of compiling this report. The national report is scheduled for publication in January 2015.
Renal replacement therapy (Renal Registry)	Yes	Yes	100%	The Sussex Kidney Unit submits data automatically to the UK Renal Registry (UKRR) and data from this is used regularly for local audit purposes. Improvements have been made to allow better recording of renal biopsy details including complications.
Rheumatoid and early inflammatory arthritis	Yes	Yes	n/a	This new national audit is still in its very early stages, having commenced on 1 February.
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes	100%	BSUH submits data regularly to the National Hip Fracture Database. Data completeness has improved as a result of the appointment of an audit officer, closer working relationship between the audit officer and clinical teams and a process of live data checks on patient notes throughout their admission. The Trust was not included in the feasibility study for the Fracture Liaison Service Database or the pilot of an inpatient falls audit, the outcomes of which will be available later in 2014. However, the Trust is actively engaged in a highly successful local programme of work to reduce the number of inpatient falls, which is reported elsewhere in this Quality Account.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	80-90%	Reports presented to both Multidisciplinary Teams at Stroke Governance meeting in Oct 2013. Challenges in meeting the standards hinge to a large extent on staffing levels. The team are therefore exploring different possibilities to improve this.
Elective surgery (National PROMs Programme)	Yes	Yes	73.9%	Provision of training for clinic staff and regular local monitoring have helped to achieve a huge improvement in overall participation rates. In February 2014, the nationally reported participation rate for BSUH rose to above the England average.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	100%	The MBRRACE-UK online reporting system for perinatal and infant deaths has been available since 10 April 2013.

Audits	Eligible	Participation	% of cases submitted to each	Action to improve quality of healthcare
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	60% approx	Recent data entry into the audit has been slow due to unexpected staff absence. However, during the past year, the Trust has successfully appointed a Clinical Nurse Specialist for epilepsy and also a second consultant with expertise in paediatric epilepsy.
Neonatal intensive and special care (NNAP)	Yes	Yes	100%	The documentation of Retinopathy of Prematurity (ROP) screening has improved over the past year and is now compliant with the NNAP standard for 2013. All data is regularly reviewed.
Paediatric intensive care (PICANet)	Yes	Yes	100%	Quality is assessed by PICANet and BSUH's data has passed. Results show the Trust has the lowest mortality rates in the UK.
Emergency use of oxygen	Yes	Yes	100%	The Respiratory team have implemented several initiatives to improve the prescription of oxygen across the Trust in the past few years. Having done these, there is now little more scope for improvement in the absence of electronic records/ prescribing.
Paracetamol overdose (care provided in emergency departments)	Yes	Yes	100%	The national report has not yet been published. This is scheduled for the end of May 2014.
Severe sepsis & septic shock	Yes	Yes	100%	The national report has not yet been published. This is scheduled for the end of May 2014.
Moderate or severe asthma in children (care provided in emergency departments)	Yes	Yes	80%	The national report has not yet been published. This is scheduled for the end of May 2014.
Child health clinical outcome review programme (CHR-UK)	Yes	Yes	100%	Data is submitted to the programme via the Office for National Statistics rather than by direct submission from the Trust. Data is used to create a large dataset and analysis of mortality, and also to identify themes for future themed case reviews.
Paediatric asthma	Yes	Yes	100%	The team have taken steps to address the delay in administration of oral steroids that was noted in some cases.
Paediatric bronchiectasis	Yes	No	n/a	The Trust will participate in the next round of this national audit.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Studies

Audit	Eligible	Participation	% of cases completed for each	Action
NCEPOD - Lower Limb Amputation	Yes	Yes	71%	This study is still open and the % of cases submitted have not been finalised.
NCEPOD - Tracheostomy Care	Yes	Yes	100%	Not yet reported
NCEPOD - Subarachnoid Haemorrhage	Yes	Yes	100%	
Alcohol Related Liver Disease	Yes	Yes	100%	

Local Clinical Audit

Local clinical audits are undertaken by individual healthcare professionals and teams in order to evaluate aspects of care that they have selected as being important to the delivery of safe, high quality care. The reports of 124 local clinical audits were submitted via the Trust's Clinical Audit intranet page. A summary of some of the audits reported is contained below.

Specialty/Team	Audit	Comments and actions to improve quality of care
A&E	Audit on Pathology reports in A&E	This audit recommended that the documentation of investigations and actions taken needed to improve and that results must be checked before the patient gets discharged.
A&E	Analgesia in the Emergency Department	Providing analgesia to patients in the Emergency Department could be improved. More education is required regarding pain and analgesia prescription.
A&E	Clinical Decision Unit/Short Stay Ward admissions	Review of patients admitted to the SSW and CDU following attendance at the A&E. Several parameters were reviewed including presenting complaint, doctor seen, length of stay, drug chart and risk assessment documentation on transfer and test results. The review identified areas for improvement including doctor to doctor handover, confusing CDU proforma and omission of regular medications.
A&E	Audit of the use of new ITU referral forms implemented in the Emergency Department	Only two forms had been used over the two week period. These had been correctly filled. Of the remaining referrals to ITU all had documentation of the referral and ITU assessment in the notes, however none met GMC guidance for documentation. Many of the ED staff were unaware of the form's existence. Education programme implemented and re-audit of the use of the forms scheduled.
A&E	Audit to assess adherence to new national guidelines on management of paracetamol overdose in the Emergency Department	N-acetylcysteine was prescribed correctly in all 22 charts reviewed with the first infusion given over 1 hour.
Acute Medicine	Audit of the recording of alcohol consumption on acute admissions proforma and correlation with the Alcohol Use Disorder Identification Test (AUDIT) to identify harmful drinkers	The audit identified inadequate identification of harmful drinkers admitted to the acute medical unit. Audit proposed better education for junior admission team about importance of complete and accurate recording of alcohol consumption of patients by unit measurement and appropriate referral to alcohol misuse team.

Specialty/Team	Audit	Comments and actions to improve quality of care
Acute Medicine	Audit of compliance with Trust guidelines on prescribing and documenting antibiotics	Re-audit of a study undertaken in 2011. The audit identified room for improvement in both the documentation of the duration of the antibiotics and ensuring that the antibiotics are given for the correct duration of time. The findings were shared at the multidisciplinary team meeting to enable learning. The team will undertake a further re-audit to monitor progress.
Care of the Elderly	Audit of management of patients following a fall in an inpatient area	Using NICE guidelines the audit identified that junior doctors documenting of post falls management could be improved. The leads for this project have developed a two page post falls proforma which is currently being piloted.
Elderly Medicine	Completeness of electronic discharge summaries to GPs	Clinical information is generally well documented. Defining health status factors is a complex area that is not clearly understood. Details such as AMTS score and reason why a medication is stopped can have significant clinical effect. Only four out of the 30 discharge summaries identified a discharge destination.
Endocrine	Audit of compliance with local guidelines concerning the management of hyperglycaemia in the context of ACS treatment	A junior doctor toolkit presentation has been devised in order to improve compliance with the guidelines, particularly in relation to laboratory checks for glucose and checking BMs at 1-2 hours for all patients with a BM >8 <10.
ENT	ENT Morbidity and Mortality audit	Baseline audit to review cases presented to the ENT M&M meeting. Audit looked at the number of cases by consultant, procedure and type of complication. Rolling audit to ensure early identification of areas of concern.
ENT	Patient Feedback. A self-audit of patient opinion during ENT outpatient clinics	Currently doctors in training are exempt from revalidation; however the programme is likely to be extended. The aim of the study was to audit own practice against validated patient feedback from across two ENT outpatient clinics; and to assess feedback, reflect and respond to comments made by patients. Although based on limited numbers of patients, the findings were positive showing 100% of patients were very satisfied with their consultation and would definitely be happy to see the same doctor again.
ENT	Myringotomy & Grommet Insertion - A self-audit of operative performance	Following a recently completed research project into use of video as an objective assessment tool in Core ENT procedure, the question was asked whether this technology could be used as the start of a self-audit to improve personal practice. The audit found improvement in eight out of nine parameters using a validated scoring system. A full re-audit cycle is due to be completed.

Specialty/Team	Audit	Comments and actions to improve quality of care
HIV / GUM	Re-audit of UTI management	Audit recommended changing prescribing guidelines to adopt cefalexin as first line treatment.
HIV / GUM	Audit into the use of Ward Round Safety Checklists within the HIV team.	Ward round safety checklists were used 54% of the time on consultant rounds. Within this there was a high percentage of drug chart checks. Areas to improve were checking of resus status and asking questions of the patient.
Maternity, Obstetrics & Gynaecology	LOS/Emergency care following diagnosis of ectopic pregnancy	Serious concerns raised via the audit escalated to divisional/Trust level. Change in protocol necessitated a re-audit of more recent data. New definitions of 'haemodynamic stability' agreed. Prospective audit launched to monitor improving trends.
Maternity, Obstetrics & Gynaecology	Care of the Perineum - An assessment of maternal awareness of pelvic floor exercises, antenatal massage & warm packs during the second-stage of labour	Greater awareness needed amongst medics, further teaching by clinical skills facilitators organised. Increased distribution of PIL in antenatal clinics. Information and PIL uploaded to 'My Pregnancy Matters' site.
Maternity, Obstetrics & Gynaecology	HIV in Pregnancy: A Ten Year Study	Development of a HIV care pathway; development of a PIL; development of a women's satisfaction survey
Maternity, Obstetrics & Gynaecology	Fetal Fibronectin	fFN machines changed to enable greater accuracy and stratification of results giving better positive predictive values for pre-term labour. R/V of pre-term labour protocol. Investigate possibility of consultant-led clinic for women with risk factors for pre-term labour
Maternity, Obstetrics and Gynaecology	Reducing Surgical Site Infection	Review of national guidance in relation to skin prep; wound dressing trial underway; BSUH sign-up to HPA SSI/LSCS surveillance project for launch July 2014.
Medicine	Competence in confirming correct placement of nasogastric feeding tubes amongst FY1 doctors	The audit identified poor knowledge of official guidelines in checking correct placement of NG tubes amongst FY1 doctors. The audit identified a need for FY1 teaching sessions and for FY1 doctors to complete the e-learning module.
Orthopaedics	Assessment and functional outcome and complications of those treated with operative fixation at one year follow up.	The group of patients over 75 selected for operative management have higher demand and longer life expectancy. Surgery under regional anaesthesia is safe, and volar plating provides excellent function and low complication risk. We recommend that surgery can be appropriate with careful patient selection, appropriate follow up and assessment and treatment for future fracture risk.

Specialty/Team	Audit	Comments and actions to improve quality of care
Paediatric ENT	Cancellation rates in paediatric adenotonsillectomy for OSA at RACH due to lack of HDU bed availability	A baseline audit was undertaken to review departmental practice regarding booking of HDU beds against the Consensus Paper of UK Working Party. A Paediatric OSA HDU Request Form was subsequently introduced to be completed in clinic by the booking clinician. Subsequent re-audit found a 56% reduction in HDU bed requests, 2-% reduction in unnecessary HDU bed requests and a 50% reduction in paediatric adenotonsillectomy cancellation rate due to lack of HDU beds.
Paediatric Surgery	Consent in Paediatric Surgery	Overall consent is done well. Areas that could be improved include ensuring all patient details filled correctly, contact details for registrars and risks and benefits documented in notes.
Paediatric Surgery	Medical Records Keeping in Paediatric Surgery	Areas to improve: documenting consultant on call, referral source, and full clinician details including bleep number. Results to inform teaching on documentation standards at induction.
Radiology and A&E	Radiology Results in BSUH Emergency Department	Lists are generated daily of A&E patients with radiology reports. FY1s check the abnormal reports to see if this abnormality was identified and what the outcome was for the patient. The audit assessed the number of mis-interpreted abnormal radiology results to identify which radiographs are more commonly mis-interpreted. Despite intervention and awareness, an increase in mis-interpreted radiographs was seen. The majority of these were not significant enough to re-call patients to ED/OPA. The biggest improvement was seen with the interpretation of AXR. However, the area least correctly interpreted was bony x-rays. Recommendations included focused teaching sessions and improved discharges on the electronic database to ensure documentation of all radiographs.
Vascular	Audit of care pathway for acute vascular patients	Audit identified a need for increased access to Interventional Radiology Services, particularly out of hours.

Quality Indicators

Quality Indicators	BSUH Rate	National Average	Best performing teaching hospital	Worse performing teaching hospital
(i) Summary Hospital-level Mortality Indicator (SHMI) (ii) the percentage of patient deaths with palliative care	(i) 0.96 (ii) 13.3	(i) 1.0 (ii) 20.9	(i) 0.75 (ii) 9.4	(i) 1.17 (ii) 40.5
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described because it taken from the national dataset.				
Brighton and Sussex University Hospitals NHS Trust has taken the following 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. The Trust Safety and Quality Committee routinely scrutinises this data and receive six monthly reports on any concerns identified. This work is supported by our Coding Department in order to ensure any clinical and non-clinical concerns are identified.				
PROMs (i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery (iv) knee replacement surgery	(i) 0.079 (ii) 0.158 (iii) 0.402 (iv) 0.275	(i) 0.086 (ii) 0.101 (iii) 0.439 (iv) 0.330	(i) 0.132 (ii) 0.158 (iii) 0.517 (iv) 0.416	(i) 0.017 (ii) 0.020 (iii) 0.301 (iv) 0.193
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons. Improved participation rates during the year have translated into a larger pool of data from which the scores are calculated.				
Brighton and Sussex University Hospitals NHS Trust intends to use these results to inform discussions about what changes should be made to improve the scores.				
Percentage of patients readmitted within 28 days (i) aged 0 to 14 (ii) aged 15 or over	(i) 9.97 (ii) 12.94	(i) 2.73 (ii) 8.77	(i) 0 (ii) 0	(i) 14.94 (ii) 17.5
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described because it taken from the national dataset.				
Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this rate. Since 2011 work has been ongoing across specialities to reduce readmissions by improving clinical pathways and through working in collaboration with other health care providers.				
The Trust's responsiveness to the personal needs of patients during reporting period.	66.7	67.2	85.0	54.6
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons. The data is produced by the Picker Institute in accordance with strict criteria.				
Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this score. An action plan that addresses the issues raised in the National Patient Satisfaction Survey has been developed and has been overseen by the Trust's Patient Experience Panel.				

Quality Indicators	BSUH Rate	National Average	Best performing teaching hospital	Worse performing teaching hospital
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	56.91	67.1	93.9	39.6
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reasons. The exercise is undertaken by an external organisation with adherence to strict protocols around sample size and selection.				
Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this percentage. The results of the survey has been presented to the Board and key actions have been agreed and will be monitored by the Board.				
Patients who would recommend the Trust to their family or friends (Friends and Family Score) (i) Inpatient Score (ii) A&E Score	(i) 65 (ii) 31	Not published	Not published	Not published
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reason. The figures submitted for the Friends and Family Score has been independently scrutinised by the Trust's internal auditors.				
Brighton and Sussex University Hospitals NHS Trust are taking the following actions to improve this score. Suggestions from patients are collected as part of the Patients' Voice survey and are implemented with the expectation that these incremental changes will improve the Trust's score.				
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period. (The VTE Score is based on the definition agreed by the local commissioners for CQUIN purposes, rather than the Department of Health's national definition)	Q1: 96.4% Q2: 96.7% Q3: 96.5% Q4: 95.6% (2013-14)	96% (2013-14)	Q1: 96.40% Q2: 96.66% Q3: 99.81% (2013-14)	Q1: 91.06% Q2: 92.10% Q3: 93.78% (2013-14)
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reason. The figures submitted for the number of patients who had a VTE assessment has been independently scrutinised by the Trust's internal auditors.				
Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this percentage. This data is routinely scrutinised at the monthly Safety and Quality Committee.				
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	Data not available	Data not available	Data not available	Data not available
Safety Incidents (i) Incidents reporting rate per 100 admissions (ii) Severe incident rate (iii) Catastrophic incident rate	(i) 5.33 (ii) 0.1 (iii) 0.1	(i) Not published (ii) 0.2 (iii) 0.1	(i) 12.8 (ii) 0 (iii) 0	(i) 4.87 (ii) 0.8 (iii) 0.3
Brighton and Sussex University Hospitals NHS Trust considers that this data is as described for the following reason. A panel of consultants reviews this data weekly in order to ensure every incident is appropriately graded.				
Brighton and Sussex University Hospitals NHS Trust has taken the following actions to improve this rate. The rate of incident reporting is monitored monthly at the Safety and Quality Committee. All incidents resulting in severe harm are fully investigated and a report is shared with the family and our partners in the local health economy.				

General Statements

Statements of Assurance from the Board

During 2013/14, Brighton and Sussex University Hospitals NHS 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.

Brighton and Sussex University Hospitals NHS 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 2013/14 represents 100 per cent of the total income generated from the provision of NHS services by Brighton and Sussex University Hospitals NHS Trust for 2013/14.

Research

The number of patients receiving relevant health services provided or sub-contracted by Brighton and Sussex University Hospitals NHS in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee is described below.

The table on the facing page illustrates recruitment against targets to portfolio studies. To account for the fact that performance can fluctuate and overachieve due to large recruiting epidemiology or screening studies the data has been presented to show actual recruitment and recruitment excluding those large studies that enrol more than 500 patients. In years 2010/11 and 2011/12 the Trust was running 1-3 large recruiting observational studies, which accounted for large peaks in performance. Adjusted figures better reflect real performance.

The total number of recruits into studies has increased year on year, as has the number of new studies being opened by the Trust. There are approximately 3000 patients either on active treatment or in follow-ups in any given year.

Recruitment against targets to portfolio studies	Studies	Recruitment Target	Recruitment Actual	Large Study (Recruitment over 500)	Number of Studies Large Studies	Recruitment (excluding large studies)	Average Recuitment per Study	Average Recruitment per Study (excluding Large Studies)
2013-14								
Interventional	125	884	781	0	0	781	6.24	7.13
Observational	68	1788	2127	0	0	2127	31.27	25.20
Total	193	2441	2908	0	0	2908	15.06	13.87
2012-13								
Interventional	94	1183	670	0	0	670	7.13	7.13
Observational	56	1258	1411	0	0	1411	25.20	25.20
Total	150	2441	2081	0	0	2081	32.32	13.87
2011-12								
Interventional	73	594	734	0	0	734	10.05	10.05
Observational	51	1592	1737	597	1	1140	34.06	22.35
Total	124	2186	2471	597	1	1874	44.11	15.11

The figures do not include commercial trials or studies that have not been submitted to the portfolio (for example projects funded by universities, small charities and non-restricted educational awards). The data only captures patients recruited in year so it does not reflect the total number of patients actively engaged in research, for example those on treatment or follow-up for more than 12 months.

Care Quality Commission

Brighton and Sussex University Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against BSUH in 2013/14. Brighton and Sussex University Hospitals NHS Trust has no conditions on its registration.

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

There have been a number of visits to the Trust by the CQC in 2013/14:

- April: Compliance visit at Royal Sussex County Hospital
- May: Compliance visit at Royal Sussex County Hospital and Princess Royal Hospital
- July: Compliance visit Bexhill
- August: Compliance visit at Hove Polyclinic and the Park Breast Centre
- December: Visit to Royal Sussex County Hospital and Princess Royal Hospital

The CQC inspection in April and May this year involved both the Royal Sussex County Hospital and the Princess Royal Hospital. The Trust was assessed in six outcomes during the April visit: two outcomes were compliant and four required further action and were deemed to have a moderate impact on patient care. These were:

- Respecting and involving people who use services (Outcome 1) - action needed
- Care and welfare of people who use services (Outcome 4) - action needed
- Partnership working (Outcome 6) - compliant
- Staffing (Outcome 13) - compliant
- Supporting staff (Outcome 14) - action needed
- Assessing and monitoring the quality of service provision (Outcome 16) - action needed

The CQC visited in May 2013 and reviewed two outcomes:

- Cleanliness and infection control (Outcome 8) - compliant and;
- Safety and suitability of premises (Outcome 10) at Princess Royal Hospital - action needed.

Care Quality Commission visit in July 2013, Bexhill

The CQC undertook a scheduled inspection of Bexhill Renal Satellite Unit on 27 June. The visit focused on the following outcomes:

- Outcome 1- Respecting and involving people who use services
- Outcome 4 - Care and welfare of the people who use the services
- Outcome 7 - Safeguarding people who use the services from abuse
- Outcome 8 – Cleanliness and infection control
- Outcome 13 - Staffing
- Outcome 14 – Supporting staff

The CQC judged that Outcomes 1 and 4 were compliant but the other four outcomes required further work. Significant progress has been made by the Renal Team on the action plan and evidence has been compiled to demonstrate compliance. The Trust Board, in December, having reviewed the evidence, confirmed, in its judgement, that outcomes 7, 8, 13 and 14 were compliant, which will be checked by CQC in further inspections at Bexhill.

Care Quality Commission visit in August 2013, Hove Polyclinic

The CQC undertook a scheduled inspection of Hove Polyclinic on 13 August. The visit focused on the following outcomes 1, 4, 7, 8, 13, 14 and 17 (complaints). The CQC commended the organisation for the systems and processes in place and the care received by patients. Full compliance was attained for all the outcomes reviewed.

Care Quality Commission visit in August 2013, Park Breast Centre

The CQC undertook a scheduled inspection of the Park Breast Centre on 13 August. The visit focused on the following outcomes 1, 4, 7, 8, 14 and 17. All outcomes reviewed were compliant.

CQC Action Plan

The Board received updates in April, June, July and December on actions taken following the CQC inspections. The Quality and Risk Committee received an update report in September and November 2013.

All actions for outcome 10 on the safety and security of premises at PRH have been completed, as approved by the Board in December 2013.

CQC visit December

The CQC visited the Trust in December 2013, in response to a number of concerns raised and involved a team of inspectors listening and speaking with patients, carers and staff. They visited a number of wards at the Royal Sussex County Hospital and the Princess Royal Hospital and observed care. A Listening Event report was published in April 2014.

The CQC report identified 'tensions' among staff in some areas, including concerns raised by some black and minority ethnic staff. The Trust provided the CQC with details of the work already underway to address some of these tensions, including the project to develop a Trust-wide set of values and behaviours. The Trust also outlined the actions we are developing to address the specific issues we have around staff from BME groups which is an extremely important piece of work for the Trust.

Data Quality

Brighton and Sussex University Hospitals NHS Trust submitted records during April 2013 to February 2014 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:

- 98.7% for admitted patient care;
- 99.4% for outpatient care; and
- 91.5% 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 outpatient care; and
- 99.9% for accident and emergency care.

Information Governance

Brighton and Sussex University Hospitals NHS Trust Information Governance Assessment Report score overall score for 2013/14 was 68% and was graded satisfactory (green).

Payment by Results

Brighton and University Hospitals NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 7%.

- Primary Diagnoses Incorrect (11.6%);
- Secondary Diagnoses Incorrect (9.8%);
- Primary Procedures Incorrect (6%);
- Secondary Procedures Incorrect (10.3%).

Part 4

Statements from Stakeholders

Joint response from Clinical Commissioning Groups - NHS Brighton and Hove, NHS Crawley, NHS Horsham and Mid Sussex, NHS High Weald Lewes Havens

Overall the CCGs are agreed that the document meets the Department of Health national guidance on Quality Account reporting and the format and content of the report is generally well presented for a public audience.

Progress in 2013/14

The CCGs note the progress made over the past year, including the reduction in patient falls, reducing pressure damage to skin, and improving safety of medicines management.

It would appear that the challenges around unscheduled care in the A&E department have created tensions elsewhere in the hospital, notably in the number of elective admissions and urgent operations cancelled on more than one occasion. This negative impact is also reflected in other care pathways such as stroke. The extra staff and better practices in the Emergency Department are welcomed. However, the CCGs require further assurance via improvement in reported patient satisfaction levels, from the Friends and Family Test results across the services and in particular A&E. The CCGs acknowledge that challenges for the Trust are also partly reflective of wider whole system issues in Social Care, Nursing Homes and Primary Care which impact on the BSUH hospital sites. A brief description of the whole system work BSUH is involved in which includes the Evergreen Project to address the challenges, would put the hospital position in a better perspective. There is generally little mention in the report of partnership working, and as many of the initiatives described benefit from the input of others, the Trust might wish to give some examples of how partnership working helps improve services.

The CQC visits and identified areas of non-compliance are significant and would have benefited from a short but simpler explanation of the reasons, with a robust response in terms of achieving and maintaining compliance going forward. The CCGs look forward to hearing from the outcome of the recent CQC visits.

Never Events and other Serious Incidents are not mentioned in the report other than as statistical calculations. It would be helpful to have some mention of lessons learned and actions put in place to prevent further occurrence.

The HCAI position of the Trust remains challenged. The target for Clostridium difficile was not achieved, although the CCGs recognise the target for 2014/15 presents a more achievable position for the Trust. The requirement of zero tolerance for MRSA was missed last year and this challenge continues into 2014/15.

Clearly the Outpatient Referral and Appointment Hub is causing concern to patients, and the work to improve the system is timely and impacts on Trust reputational issues.

Priorities for 2014/15

The priorities outlined are appropriate as they focus upon patient experience and safety. The emphasis upon involving patients and listening to staff and patient feedback is welcome, especially in light of relatively poor Friends and Family Test results and the national 2013 staff survey.

The CCGs look forward to seeing evidence of improvements being made as a result of patient and staff feedback. The values and behaviours programme is a welcome start in addressing the identified longstanding cultural and behavioural issues present within the organisation. An employee support programme if embedded, will help to raise staff morale and consequently drive up patient satisfaction levels. The poor staff appraisal and training rates also need addressing in this context. The CCGs look forward to practical examples of improvement in employee morale and patient satisfaction especially where communication, advice, and complaints handling are concerned.

Recruitment and retention strategies are high risk areas for many organisations, and the workforce implications in maintaining services and planning for the new Teaching, Trauma and Tertiary Services (3Ts) are considerable. It would be helpful to hear how the Trust plans to bridge gaps in recruitment and develop the necessary skill sets to move to the new culture outlined in the report.

Overall, more emphasis upon staff and patient perceptions of the organisation, together with practical examples of how the Trust plans to accelerate improvement in these areas, would be helpful additions to priorities going forward.

Conclusion

The Trust has made very good progress in some areas against its priorities for 2013/14. The emphasis upon values and behaviours is welcomed, and the recognition of the need to improve the BME workforce experience in some areas is positive. There is a great deal of work to be done in order to build on improvements to patient safety and patient and staff experience. The results from the Friends and Family Test and other surveys merit real focus and investment in making the Trust an organisation where both patients and staff would be happy to receive care. It is acknowledged that the need to accelerate change whilst keeping the workforce motivated is very challenging for the Trust Board.

The CCGs look forward to continuing to work with the Trust in implementing further quality improvements over the next year.

Brighton and Hove City Council's Health and Wellbeing Overview and Scrutiny Committee (HOSC)

Brighton and Hove City Council's Health and Wellbeing Overview and Scrutiny Committee has continued to have a keen interest in the work of BSUH over 2013/14. We have welcomed the open nature of the communication and discussions that we have had with the Trust over the year on a variety of stimulating issues including A&E admissions and performance rates. As a committee we have challenged BSUH on a number of occasions and we have always received a full and honest response from the Trust, who are happy to engage and consult with us. We appreciate the dialogue that we have with BSUH and look forward to continuing this in forthcoming years.

Healthwatch Brighton and Hove

Healthwatch Brighton and Hove is pleased that BSUH is sharing important issues with us, and working with us more closely as we have transitioned from LINk.

- 'Unscheduled care (page 18) - "Achieving the four hour standard will not be a Quality Account Priority in 2014/15. However, this target will continue to be monitored via the Trust Scorecard."

We are not clear why this won't be a priority for 2014/15 (it might well be a national decision). However, from a patient's perspective the four hour target is an important one and we consider it should be high on the Trust's agenda. Waiting times at A&E was an issue highlighted by 35% of respondents in our survey on Urgent Care http://tinyurl.com/o57jdyf.

- Improving communication with Primary Care - "Did not achieve automating letters that go to GPs after a person has been discharged from hospital. Should be completed by Dec 2014." (Page 19)

We are disappointed that this has not been achieved as from a patient's perspective this can mean delays obtaining prescriptions etc. Healthwatch will be monitoring this to ensure it is completed by December 2014.

- Elderly medicine audit - "Only 4 out of the 30 discharge summaries identified a discharge destination." (Page 37)

This is an issue which Healthwatch Brighton and Hove hope to pick up in our research on hospital discharge.

- "Quality reviews, 'Sit and See', are used as a form of peer review whereby multidisciplinary teams visit areas using the framework around quality of care, kindness and compassion." (Page 22)

Healthwatch Brighton and Hove is pleased to see that this innovative tool is continuing to be used within the Trust.

- "The Friends and Family Question of whether you (the patient) would recommend this hospital to a relative or friend is also asked in A&E and will be extended to outpatients during 2014/15." (Page 21)

The extension of the Friends and Family question is a positive step and Healthwatch Brighton and Hove look forward to seeing the results.

- "2014/15 goal(s): The target for this year is to reduce the falls rate by a further 10%, this would mean bringing the rate down to 3.12 falls per 1,000 bed stay days." (Page 9)

Healthwatch Brighton and Hove are pleased that the incidence of falls have been reduced at the Trust but would like to see the number of avoidable falls decrease by more than a further 10%. From a patient's perspective falls can cause significant distress/pain etc.

- "Not Achieved: The Trust target was to have no more than 34 hospital acquired cases of Clostridium difficile and zero avoidable MRSA bacteraemias. During 2013/14 we have had 48 hospital acquired cases of Clostridium difficile and two MRSA bacteraemias that were potentially avoidable." (Page 13)

Healthwatch Brighton and Hove are disappointed that the infection target has not been met and hope that the Trust will significantly reduce the infection rate next year.

Healthwatch West Sussex

Introduction

Healthwatch West Sussex is grateful to BSUH (the Trust) for the enhanced level of engagement during the preparation of this year's Quality Accounts (QA). This has enabled us to understand better the role played by the QA in the Trust's aspiration for high quality care and to influence the focus of some of their quality markers. We know that the Trust's report has to meet the requirements of several audiences, which does mean that the full QA (at 53 pages) is challenging for the general public to grasp. As the independent champion for health and social care consumers in West Sussex, Healthwatch West Sussex has a responsibility to review and comment on Quality Accounts from the consumer perspective as reflected in our comments below.

General Approach

We have seen good evidence that the Trust has both organisational arrangements and cultural processes in place to embed a commitment to quality up to Board level. Some of the very visible work at ward level is impressive and should give the public and patients assurance that issues they have raised are being addressed.

Comments on 2013/14 Quality Account

Improvement in Outcomes

The reduction in Patient Falls and Avoidable Bed Sores is good news as is the Trust's commitment to continuing the downward trajectory. Other indicators such as Mortality, Venal Thromboembolism and the results of a number of audits show good progress. However, the Safety Thermometer Index is only marginally better than the national average. We would suggest the inclusion of tables showing trends where a number of years data is available, facilitating comparisons and assessment of performance from the consumer perspective.

Plans to address weaker areas

The Trust is open about its failure on the four hour A&E target and shows continued vigilance on the target to reduce Hospital Acquired Infection. Patients and families are regularly concerned about communication during Transfer of Care whether within a hospital, between hospitals or into primary care. The Trust has identified these as weak areas and appears to have plans in place to address them. It is disappointing that little progress has been made on improving communication with GP surgeries. We will be especially interested to see the outcome of this work. The Trust's weak performance on staff confidence does not feature in the CEO's introduction and is given relatively little profile elsewhere. This may well be addressed through its Values and Behaviours initiative but it does not appear to have been given the significance it deserves in the QA report.

Listening to and acting on patient concerns

The innovative ward-based work is not easily seen from a high level report such as this. However, we have seen good evidence where individual wards have reached out to patients and the public, listened to their concerns and publicised the actions they have taken.

Providing accessible services

The Trust acknowledges that addressing better access in A&E requires a whole systems approach and it would be good if a specific improvement target was set for 2014/15. Physical access is also a continuing concern for patients and we have received adverse comments about parking at PRH.

Responding to National reports

It is good to see the work being developed by the Trust in response to the Francis Report focusing on the growing number of frail elderly patients and their special needs. This initiative should not only improve patient experience but should also be a cost effective intervention for both the Trust and the community.

The Princess Royal Hospital (PRH)

The Trust provides a single QA report which makes it impossible to disaggregate the performance of PRH as a provider within West Sussex. However, where there are issues around communication with patients (e.g. booking appointments or obtaining information) these are exacerbated by being a "remote site". This concern is reflected in the comments Healthwatch West Sussex has received and we would wish to discuss with the Trust the possibility of a small number of PRH specific targets next year (e.g. mortality or hospital acquired infection rates).

Conclusion

The Trust is attempting to make progress on a large number of topics not all of which will have been included in the QA report. We do not underestimate the scale of the task but consider that the Trust would be in a better position to evidence progress if all its objectives/goals were appropriately quantified and measurable. The Trust has a number of major initiatives underway, including the Values and Behaviours programme; Foundations for Success programme; Towards a Safer Hospital project. It would be helpful if the QA report outlined an overarching strategy/plan where each of these tackled a major segment of the overall quality spectrum. Finally we acknowledge that the Trust has engaged well with us on PLACE (Patient Led Assessment of the Care Environment) audits together with explanation of the problems with removal of the central appointments system from PRH to Brighton at the start of 2014.

Healthwatch West Sussex looks forward to continuation in improvement in its relationship with the Trust and jointly reviewing performance from the patient and public perspective.

West Sussex Health and Adult Social Care Select Committee (HASC)

Overall, we do not necessarily find the Quality Account format very “user friendly” but understand that you are following national requirements. Quality Accounts tend to be too long and too detailed to provide the kind of information that is readily digestible by the public and lay-people. However, your Quality Account for 2013/14 is a clear, public-facing document which presents key quality and performance issues in a very readable format. It is particularly helpful that you combine information on achievements during the past year with your goals for 2014/15. We welcome your focus on safety and quality and the fact that you have put the patient at the centre of your plans, as demonstrated by the seven questions around which you will develop your strategy for the future.

There has clearly been some good performance at the Trust during 2013/14. You have achieved most targets, and where targets have not been achieved you have clearly explained why and how you are addressing these. However, some of these areas of underperformance are critical to ensuring good patient experience and outcomes, and it will be important to monitor these, particularly: medication reconciliation; reducing hospital acquired infections; improving nutrition screening; and improving patient transfer. Communications with Primary Care would also appear to need improvement, but it might also be useful to understand how well you are working with community health and social care services.

A&E services are a key concern for the Committee – and the wider public – and it is disappointing that you have not been able to improve patient flow within the hospital. We understand that there is significant pressure on emergency services, with rising A&E attendances across the country, but are particularly concerned at reported handover delays between the Ambulance Service and Royal Sussex County Hospital. HASC will be reviewing this later in 2014, but hope that the Trust will continue to monitor this and to work with the Ambulance Service and other key partners, including Community Health Services, Primary Care and social care services across Sussex.

Other areas of concern that have been raised by HASC are the need to improve outcomes for stroke patients; to improve awareness of dementia by all staff in the acute hospital setting; and to ensure the appropriate mental health support is available in A&E. We hope that you will be able to take these into consideration during 2014-15.

Finally, a priority for the future must be ensuring safe, high quality services that are sustainable and deliverable for the future. This is not something you can achieve in isolation – it will require the whole health and social care system to work together to meet the challenges of increasing demand, pressure on services and financial constraints.

We welcome the continued open dialogue and liaison arrangements between BSUH and the HASC, and look forward to working with you in 2014/15.

Independent Auditors' Limited Assurance

Independent Auditors' limited assurance report to the Directors of Brighton and Sussex University Hospitals NHS Trust on the annual Quality Account.

We are required by the Audit Commission to perform an independent assurance engagement in respect of Brighton and Sussex University Hospitals NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Friends & Family Test – patient element score (page 21 of the Quality Account); and
- Percentage of VTE Risk Assessments (page 10 of the Quality Account).

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to April 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated June 2014;
- feedback from Local Healthwatch dated June 2014;
- the trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 25/03/2013;
- the latest national staff survey dated December 2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated April 2014;
- the annual governance statement dated 05/06/2014; and
- the results of the Payment by Results coding review dated April 2014.

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

This report, including the conclusion, is made solely to the Board of Directors of Brighton and Sussex University Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Brighton and Sussex University Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

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

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

Limitations

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

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

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

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

Basis for qualified conclusion

The indicator relating to the percentage of VTE risk assessments was not calculated using the full population of patients admitted as maternity cases in 2013-14 were excluded. However the Trust has started to do so from April 2014.

The limited population from which the indicator is calculated has an impact on each of the six dimensions of data quality specified in the guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above in respect of the indicators in the Quality Account, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

Ernst & Young LLP
Reading
30 June 2014

Statement of 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 VTE risk assessment score on page 31 of the Quality Account is based on a definition agreed with local commissioners, rather than the national Department of Health definition.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Matthew Kershaw
Chief Executive

Julian Lee
Chairman

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