Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**29th March 2016**
Board Sponsor:	**Chair, Quality and Risk Committee**
Paper Author:	**Chair, Quality and Risk Committee**
Subject:	**Quality and Risk Committee – February 2016**

Executive Summary

The report summarises the Committee discussions in respect of: Serious Incidents and Never Events; mortality indicators; progress with the duty of candour; the development of a strategic clinical audit programme; patient experience; and the outcome of the Medical Engagement Scale (MES) survey

Links to corporate objectives	The report concerns the objectives of ***excellent outcomes; great experience; and empowered skilled staff***
Identified risks and risk management actions	The key risks discussed at the Committee concern: • Poor levels of medical engagement identified through the Medical Engagement Score (MES) survey • The 7 Never Events reported in 2015/16 to date • The increase in the Summary-Hospital Level Mortality Indicator (SHMI) which is subject to detailed review
Resource implications	None
Report history	The Chair of the Committee report to the Board following each meeting of the Committee
Appendices	None

Action required by the Board
The Board is asked to note the Quality and Risk Committee report; with particular reference to the key risks discussed at the Committee.

Report to the Board of Directors, 29th March 2016
Quality and Risk Committee Report

Introduction

This was my first meeting as Chair of the Committee; the self-assessment carried out by its Members emphasised the need for a thorough review of the Committee, including; its function, the quality of thedata presented to it, the emphasis of the reports to reflect the quality, safety and performance issues facing the Trust overall, as well as its membership. This will take place prior to the next meeting in April.

Serious Incidents and Never Events

The Committee discussed reported Serious Incidents and Never Events in 2015/16 with a particular focus on the 7 Never Events reported in 2015/16 to date, all in Theatres. The Trust is a national outlier for Never Events and this represents a significant concern. The Committee welcomed the Directorate Lead Nurse, Perioperative to the meeting, who talked about the work around team-building and culture in Theatres.

The Medical Director also advised the Committee on the additional controls in theatres. However some elements of the safety culture in theatres reported through the cultural survey remain of concern and given the high number of reported Never Events the Committee will keep this area under close review. The committee has agreed to do deep dives into Serious incidents to ensure that the reported improvements have been put into place and are working to a high standard.

Mortality Review

The Committee was advised that while the Hospital Standardised Mortality Ratio (HSMR) at 92 and Summary Hospital-Level Mortality Indicator (SHMI) at 97 remained below the national average, the SHMI had seen an increase which was outside normal variation.

At this stage it is unclear whether or not this concerns the safety and quality of care in the hospital, the timeliness of discharge, or care post-discharge. The Committee will receive a further report in April following a detailed case notes review to establish the reasons for this trend. The possibility of an increase in deaths immediately post discharge has highlighted the need to strengthen the relationship and communication between primary and secondary care. The committee would like the CCGs to attend the Q&R meetings.

Duty of candour

The Trust has a well-developed process for the Duty of Candour which we are told was implemented earlier than in some other Trusts. However, the Trust is currently falling short of the national target for informing patients of reportable incidents under the Duty of Candour and it is also missing the local target for sharing investigating findings. Further work is also being undertaken to improve the quality of investigations undertaken by the Directorates, although it is dependent on clinical engagement which is now a recognised problem 9see below)

National and local clinical audits

Progress is being made in developing a coordinated plan for local clinical audits. The Committee is concerned about the high volume of local clinical audits which totaled around 400. There was no clarity about how they had been prioritised, nor their added value or whether they are always an appropriate use of scarce resource.

Therefore the current audit profile will be reviewed. The Committee was also advised that the Trust participated in 33 of the 35 national clinical audits.

Patient experience and complaints

Both the Trust data, which showed more timely responses to complainants and the internal audit, which gave GREEN assurance, showed the Trust manages complaints effectively.

The Committee was advised that the volume of complaints is highest in high-risk areas such as the Emergency Department, Digestive Diseases and neurosciences, although this is not exclusive. There are also a high number of complaints concerning waiting times and appointments for out-patients and surgery, and communication around waiting times.

Medical engagement

The Committee was advised of the poor outcome of the Medical Engagement Score (MES) survey, with the Trust scores being significantly worse than comparator Trusts, and in the bottom 20% of responders overall. There was variation in the levels of reported engagement and services with major operational or team-working challenges, such as the Acute Floor and Obstetrics and Gynaecology also showed the poorest levels of engagement. The MES scores also mirrored the findings of the National Staff Survey, which were equally poor.

The Committee discussed the outcome of the MES and the fact that clinical engagement is essential to ensure the delivery of safe, high quality, patient care, as well as improving the overall performance of the Trust. The Medical Director will attempt to identify which factors are supporting or inhibiting engagement and bring this report to the board together with the plans for improving engagement and instigating culture change within the clinical teams.

Overall the MES results are concerning and very significant work is required to improve medical engagement. The Committee was advised of the actions planned

Dr Farine Clarke
Chair
Quality and Risk Committee
March 2016