Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**24th August 2015**
Board Sponsor:	**Chair Quality and Risk Committee**
Paper Author:	**Chair Quality and Risk Committee**
Subject:	**Quality and Risk Committee – July 2015**

Executive Summary

The report describes the discussions at the May meeting of the Committee which discussed a six-monthly Serious Incidents report, and the annual reports on Complaints and Patient Experience, and Litigation.

The Committee also discussed *Early Warning Signals* and reviewed the Safety and Quality Scorecard, agreeing that its focus would be on risk issues identified through both internal and external intelligence.

Links to corporate objectives	Discussions at the Committee focused on the objectives of ***excellent outcomes;*** and ***great experience***
Identified risks and risk management actions	The Committee noted: • the Trust was an outlier in respect of reported 12 hour breaches; • the themes in the annual litigation report which included consent and delayed diagnosis and treatment; • those service areas which had received the highest number of patient complaints – digestive diseases, orthopaedics and cardiology - with concerns from patients around outpatient appointments and surgery dates, cancelled surgery and communication
Resource implications	None relevant to this report
Report history	The Chair of the Committee reports to the Board following each meeting of the Committee

Action required by the Board

The Board is asked to note the Quality and Risk Committee report.

Report to the Board of Directors, 24th August 2015
Quality and Risk Committee Report

Serious incidents

The Committee received a report from the Head of Clinical Investigations which described the Serious Incidents reported between January and June 2015, their root causes and lessons learned. This included a number of reported 12 hour breaches, falls resulting in harm, and incidents arising from a delayed diagnosis or appointment

The Committee was advised that the Trust was an outlier for 12 hour breaches and discussed the data collection and analysis of breaches of the Accident and Emergency standard, along with the plans to address the problems causing long waits.

The Clinical Director further advised the Committee on the main reasons for the 12 hour breaches, which derived from delays in admitting patients from the Emergency Department. The changes which had been made in optimising practice to improve patient flow had only been partially successful, and the further changes to clinical pathways and capacity, which were planned, were also explained.

The Committee further discussed delays in screening and diagnostic processes and the Deputy Medical Director advised on the improvements made to the screening and referral of *First Fits* following the human factors analysis of the processes involved, but that there were other inefficient administrative processes which contributed to delays.

In discussing the number of falls resulting in harm to patients, the Chief Nurse advised that a number of those falls had arisen in patients whose transfers to other care settings had been delayed.

The Committee then discussed what level of information it should receive to carry out its assurance function and it was agreed that it would be helpful to have benchmarked information, where available, with a focus on the most important themes, and evidence of lessons learned (or not learned).

Early warning signals

The Deputy Medical Director introduced a discussion on Early Warning Signals and discussed the monthly Safety and Quality Scorecard which reported a number of indicators Trust-wide and by clinical directorate, and was aligned with the Safety, Quality and Patient Experience Strategy.

The Deputy Medical Director noted the challenges in identifying early warning signals from routine data, advising that the problems in the Acute Medical Unit (AMU) had not been evident in, for example, reported incidents, or mortality data. Similarly, the review of Digestive Diseases had found that clinical outcomes were as expected, although there were concerns raised in data about patient experience. This demonstrated the importance of 'soft' intelligence including concerns raised by staff, and of triangulating all available data sources.

The Committee discussed the Scorecard and agreed that its main use was at directorate level and in identifying differences between directorates.

Annual litigation report

The Committee also received the annual litigation report from the Medico-legal services manager which described the number of new claims, the value of claims settlements; and the issues and themes arising from claims**.** The recurrent themes included delays in diagnosis and treatment, consent, documentation, communication, delegation to junior staff and failure to follow existing protocols or guidelines.

The Committee discussed the themes arising from claims and inquests and it agreed that it would be helpful to review those key themes in more detail, including the issues around consent, which it will discuss in September. The Committee discussed training around consent, and the link with requirements around candour and concerns around communication.

The Committee also noted the relatively higher volume of claims in Digestive Diseases, the acute floor, and orthopaedics, which correlated with other discussions at the Committee and the Board.

Complaints Annual Report

The Committee received the annual report from the Head of Patient Experience, PALS and Complaints which note that 1,305 complaints had been received in 2014/15, which was the median average for the last 5 years. However the content of complaints had become increasingly complex and a sustained fall in the complaint team's ability to close cases within timeframe had been identified and a growing backlog. Following an external assessment of the complaints service, the complaints team capacity had been increased by one substantive post. Together with a six month PALS Adviser secondment, this had allowed a more innovative use of the PALS service in resolving informal concerns before they progress to a formal complaint and response times were now showing steady improvement, with 77% of complaints now responded to within 40 working days. The Committee welcomed this improvement.

The Committee noted that the Orthopaedic, Digestive Diseases and cardiology specialties continued to receive the highest number of complaints and PALS contacts, concerning, in the main, waits for outpatient appointments and surgery dates, cancelled surgery and communication.

The Committee was assured that complaints are managed effectively with only one complaint accepted for formal investigation by the Parliamentary and Health Service Ombudsman (PHSO) being fully upheld, and requiring additional work to be undertaken to ensure that lesson have been learnt from the failings identified and the principles of remedy applied in respect of the complainant.

The Committee also noted the results of the Friends and Family Test (FFT), positive in maternity services where a higher percentage of women recommended BSUH services at all points in their care. The inpatient FFT was slightly lower than the national average; and the A&E FFT significantly lower than the national average, particularly at RSCH, although the volume of responses and the proportion of positive responses had improved more recently.

Care Quality Commission

The Committee noted the monthly CQC assurance briefing.

Board Assurance Framework

The Committee noted the Quarter 1 risks for which Quality and Risk was the lead Assurance Committee.

Professor Malcolm Reed
Chair, Quality and Risk Committee
August 2015