Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**30th November 2015**
Board Sponsor:	**Chair Quality and Risk Committee**
Paper Author:	**Chair Quality and Risk Committee**
Subject:	**Quality and Risk Committee – November 2015**

Executive Summary

The report describes the discussions at the November meeting of the Committee which: discussed Never Events and the lessons learned from those incidents which have been reported since April 2016; trends in falls, the improvements made by the Trust and the outcome of the national Falls Audit; a report on patient experience and complaints; and progress made against the Quality Accounts priorities.

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 discussed the outcome of the investigations into the 6 Never Events reported this year and the actions the Trust has taken following those incidents. The Committee also noted the apparent increased trend in the Summary Hospital-Level Mortality Indicator (SHMI) which was being subject to detailed review
Resource implications	None relevant to the 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, 30 November 2015
Quality and Risk Committee Report

1. Never Events

The Medical Director reported to the Committee on the six Never Events which had been reported since April 2015, and the outcomes of the investigations into those incidents and the lessons learned. This sequence of Never Events followed a long period where no Never Events had been reported. An earlier cluster of Never Events had led to the external review of theatre safety and culture which the Chief Nurse commissioned and which the Committee had reviewed.

The Medical Director noted that the number of Never Events reported by the Trust had also resulted in increased scrutiny from the TDA and CCGs and the Medical Director informed the Committee of a helpful, recent discussion with the TDA, which had focused on human factors and the need for underlying culture change, which was being addressed through Perioperative forums. Attendance at these forums was being formalised and responsibilities clarified, for example prosthesis checking.

The Committee also discussed the reporting of Never Events which was considered to be appropriate and transparent via the Trust incident reporting system, while noting that incidents other than Never Events may cause greater harm to patients, and the Trust also needed to those incidents or near misses which did not meet the criteria for Never Events.

The Committee further discussed the effectiveness of clinical governance arrangements within the directorates and specialties, and was advised that the Safety and Quality team had implemented a system of directorate reporting and was mid-way through a review of directorate governance. The Committee will be updated on this in the New Year. The key focus for development was on human factors and team training with a clinical governance day planned for April next year.

The Committee also noted the importance of benchmarking the Trust position to carry out its work effectively in respect of Never Events and other metrics.

2. Falls

The Committee received a report on progress of the Trusts Inpatient Falls programme which commenced in 2010. Both Trust and national data from the Royal College of Physicians national falls audit demonstrates the progress the Trust has made in reducing falls. Overall the Trust has demonstrated a year on year reduction in the inpatient falls rate which has come down from 6.22 falls per 100 bed stay days in 2009-10 to 3.34 in 2015-16.

The recent national audit by the Royal College of Physicians also benchmarked the Trusts falls rate with other hospitals and showed that the Trust falls rate was half the national average putting the Trust in the top five in performance.

However lessons continue to be learned and improvements made from falls investigations with a focus on establishing a falls history from patients and carers, assessing patients for lying and standing blood pressure and for any urinary continence issues.

The Committee welcomed the progress made noting the underlying focus on behavioural change and staff involvement in change rather than action plans and the potential application of this approach to other areas of quality improvement.

3. Patient experience and complaints

The Committee received a quarterly report on patient experience and complaints, with a focus on the content of complaints around communications, with some areas, for example, neurosciences, having a higher proportion of communications-related complaints than other areas. This category also included

communication around treatment pathways and waiting times, surgery dates and delays in receiving results, as well as phone calls not being returned. Overall, complaints about communication were less about staff attitudes and more about the communication of information, although the Committee was concerned that the volume of complaints appeared to be higher in some of the high risk areas.

It was noted that the Emergency Department, Orthopaedic, and Digestive Diseases specialities had received the most complaints since April 2015.

The Committee also noted that there had been a sustained improvement in the Friends and Family Test (FFT) return rate and performance in September was slightly higher than the national average.

4. Safety and quality dashboard

The Committee also received the latest iteration of the Safety and Quality dashboard which showed the following key trends over the last 12 months:

- A significant increase in Never Events
- A decrease in the number of patient safety incidents open for more than 45 working days
- An improvement in two patient satisfaction measures: ***Being Treated as an Individual and Being Involved in Decision Making.***
- A reduction in the number of complaints received about clinical care
- An increase in the number of PALs enquiries

The Committee discussed the latest mortality indicators in detail, noting an apparent increase in the Trust Summary Hospital-Level Mortality Indicator (SHMI), although this remained lower than the national average. A detailed case note review would be undertaken to identify the reasons for this and the Committee also asked for assurance that we were not discharging patients prematurely because of the pressures on patient flow.

The Committee also asked for a further report on the implementation of the Duty of Candour at its next meeting.

5. Quality Accounts Priorities

The Committee noted a report on progress with the Quality Accounts priorities and was advised that the patient transfer project had evolved into the *Right Care Right Place Each Time* programme led by the Clinical Director for Specialty Medicine, and which was making good progress in its roll out across the hospital. The Chief Nurse also advised the Committee that a schedule of quality review visits was being organised and which would include Executive and Non-Executive Directors.

Professor Malcolm Reed
Chair, Quality and Risk Committee
November 2015