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

Executive summary

The Quality and Risk Committee received a report on progress with the actions undertaken following the external review of theatre safety and culture; received assurance that no untoward safety issues had been identified following the investigation into the higher number of deaths (locally and nationally) in December and January; and discussed with the Acute Floor team the actions planned and completed to address safety concerns in the Acute Medical Unit (AMU).

The Committee discussed the Quality Accounts priorities for 2014/15 and recommended that they be reframed with a clear patient focus; and recommended that the Trust review its whistle-blowing framework in the light of the most recent Francis report.

Links to strategic objectives	Best and Safest Care √
Identified risks and risk management actions	The Committee discussed the management actions in respect of theatre safety; and patient safety in the Acute Medical Unit, and received assurance of progress
Resource implications	The actions around theatre safety and the AMU incorporate e.g. planned investment in a second obstetric theatre; and investment in staffing in the AMU
Legal implications	Concerns about patient safety in the AMU include a number of regulation 28 letters received from the Coroner
Report history	A report is made to the Board after each Committee meeting
Appendices	None

Action required by the Board
The Board is asked to discuss the Quality and Risk Committee report and any further actions to be taken

Report from the Quality and Risk Committee for the Board of Directors held on 30th March 2015

Purpose

To report to the Board of Directors matters discussed at the Quality and Risk Committee since the last meeting.

Theatres Review

The Committee received an update on progress with the actions following the Theatres Review from the Perioperative Directorate Lead Nurse, which includes work around human factors; safety walk-rounds; the standardisation of practice and theatre specific Values and Behaviours workshops. A recent near miss highlighted on-going concerns around culture, documentation and escalation, and learning from the incident will be shared via the Perioperative Forum following the After Action Review (AAR).

The Committee agreed that leadership and cultural engagement at a senior level was critical to building on the progress made to date. The Committee also noted the particular challenges in 'outlying' areas of practice, for example, in obstetrics and interventional radiology.

Mortality

The high number of patient's deaths in December 2014 and January 2015, which were discussed at the Board in February prompted further investigation. The outcome of the investigation showed that while the actual number of deaths was high in December and January , this was also the case nationally and the Hospital Standardised Mortality Ration (HSMR) for December 2014 remained below 100. No untoward safety issues have been identified to date.

Acute Medical Unit

The Clinical Director and Head of Nursing for the Acute Floor reported on the actions taken by the Acute Floor Directorate to address the concerns identified in respect of patient safety and the purpose and functioning of the Acute Medical Unit. The Committee noted the very challenging environment in the AMU which had over time become a high acuity admission ward without changes to its staff or governance

The Committee was assured by the multi-professional engagement with this programme of change, and noted, in particular, work to improve the care of patients with dementia, including plans to have a dementia nurse specialist at the 'front door' of the hospital

Quality Accounts priorities 2015/16

The Committee discussed a long list of potential Quality Accounts priorities for 2014/15, in the context of the draft Safety and Quality Strategy, and agreed that the priorities should be reframed to reflect the patient focus of the

Strategy. The Committee also agreed that a number of the potential priorities represented business as usual and the focus for 2015/16 should be on areas which required additional focus or resource.

Patient Safety Ombudsman Panel

The Committee received the draft minutes of the February meeting of the Panel, and agreed that in the context of the Francis report on whistle-blowing, the Trust should undertake a thorough review of its whistle-blowing arrangements.

Care Quality Commission

The Committee noted the high risk areas in the CQC action plan around patient flow and staffing, and the negative findings in the national staff survey around appraisal and staff engagement, together with emerging risks around the storage of equipment and the safe care of outlying patients. The committee sought and received reassurance that the CQC process was highlighting genuine areas for focused activity and that the continued scrutiny of CQC was driving concerted efforts and improvements in these areas of concern.

Professor Malcolm Reed
Chair, Quality and Risk Committee
March 2015