Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**27th April 2015**
Board Sponsor:	**Chair, Quality and Risk Committee**
Paper Author:	**Chair, Quality and Risk Committee**
Subject:	**Quality and Risk Committee Annual Report**

Executive summary

The report summarises the work of the Quality and Risk Committee in 2014/15.

The Committee has focused its work on challenges in individual specialties and risks to patient safety through Trust-wide challenges, including patient flow.

The Committee also received a received a report from the author of the external review of theatre safety and culture, and progress reports on the recommendations arising from the review.

The Committee has also given consideration to: safeguarding adults and children; complaints; mortality; the actions arising from the CQC inspection; and whistle-blowing arrangements through the Patient Safety Ombudsman (PSO) Advisory Panel

Links to corporate objectives	The Committee is a critical component of the Trust quality governance framework in assuring ***excellent outcomes; and great experience***
Identified risks and risk management actions	The Committee reviews the risks relevant to its responsibilities each quarter through the Board Assurance Framework
Report history	The Committee reports to the Board following each of its meetings
Appendices	Quality and Risk Committee, terms of reference

Action required by the Board

The Board is asked to note the annual report and approve the revised terms of reference

Report to the Board of Directors, 27th April 2015

Annual Report from the Quality and Risk Committee

1. Purpose

This report describes the work of the Quality and Risk Committee in 2014/15.

2. Membership

The Committee is chaired by Professor Malcolm Reed, Dean of Brighton and Sussex Medical School (BSMS), from March 2015, and was previously chaired by Professor Michael Farthing, Vice-Chancellor of Sussex University.

The other members of the Committee are Stephen Woodford and Christine Farnish, Non-Executive Directors; Dr Stephen Holmberg, Medical Director; Sherree Fagge, Chief Nurse; and Dr Stephen Drage, Deputy Medical Director (Safety and Quality).

Meetings are routinely attended by senior clinical and managerial staff presenting reports.

Committee terms of reference

The Committee reviewed its terms of reference in March 2015, and the revised terms of reference are submitted to the Board for approval

The key elements of the work of the Committee are described below.

3. Medical Director's reports

The Medical Director has reported to the Committee, throughout the year on issues and actions to address difficulties in a number of specialties, together with Trust-wide patient safety challenges.

Over the year good progress has been made in the majority of individual specialties, with on-going work in obstetrics and gynaecology and digestive diseases, in particular.

The balance of challenges to patient safety and quality has shifted to systemic Trust-wide challenges, and their impact on patient safety and patient experience in the emergency pathway.

Acute Medical Unit (AMU)

The Committee has given particular attention to concerns raised regarding the Acute Medical Unit (AMU) and received a report from the Clinical Director and Head of Nursing for the Acute Floor on the actions taken to address the concerns identified in respect of patient safety and the purpose and functioning of the Acute Medical Unit. 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

Cardiac surgery

The Committee's initial focus, in respect of individual specialties, concerned cardiac surgery where an elevated mortality profile and critical Royal College review had raised concerns about patient safety and led to agreed restrictions on practice. The Committee has kept the action plan for the unit under review, to the point when those restrictions were removed.

The model of an external Clinical Oversight Group has been useful and has subsequently been applied in other areas.

Digestive Diseases

The Medical Director commissioned an investigation into concerns raised in Digestive Diseases and the investigation found concerns regarding: challenges in team-working and leadership issues; concerns around the quota management of patients and planned patient pathways; and staff shortages which affected the efficiency of the new working rota.

An overarching action plan has been developed to incorporate actions arising from this and the other reviews, with some positive developments and progress which are actively monitored internally and through an external Clinical Oversight Group.

4. Never Events and Theatres Review

An external review of theatre safety and culture was commissioned by the Chief Nurse following a number of Never Events which occurred in theatres in 2014.

The Committee discussed the external review in November when Professor Reid, author of the review, attended the Committee and presented her views on the report findings. While this provided some assurance generally about safety in the hospitals, there were particular concerns about the environment and behaviours in the Sussex Eye Hospital and the need for second obstetric theatre which Professor Reid referred to as a high risk.

The review also made a number of findings in relation to: workforce capability, including the obstetrics theatres; clinical leadership; the role of human factors in theatre safety; the positive findings in relation to the privacy and dignity of patients; the effect of individual behaviours on team-working; the application of the WHO checklist in some areas; perioperative discipline in relation to swab practice; and work required to improve the standardisation of practice.

The Committee has received regular updates on progress, most recently in March when the Perioperative Directorate Lead Nurse, advised the Committee on work around human factors; safety walk-rounds; the standardisation of practice and theatre specific Values and Behaviours workshops.

5. CQC Inspection

The Committee has received bi-monthly reports on the findings from the CQC Chief Inspector of Hospitals visit in May 2014 and progress with the action plan submitted to CQC in September 2014.

The Committee has 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.

6. Mortality

The Committee has kept the mortality profile in the Trust under review, including alerts in individual specialties and received assurance regarding the explanation for the alerts together with actions taken.

The high number of patient deaths in December 2014 and January 2015 prompted further investigation which showed that while the actual number of deaths was high in this period, this was also the case nationally and no untoward safety issues have been identified to date.

7. **Complaints**

The Committee discussed the outcome of an external review of the Trust complaints management system.

The review overall found strengths and weaknesses in the way in which the Trust managed complaints, and concluded that the Trust was committed to addressing complaints in an open and honest way; but while the Trust is committed to learning from complaints it could do more to demonstrate the learning that takes place and the changes that occur as a result of a single complaint or a wider trend; and the complaints team were managing high caseloads which are not sustainable within the current structure.

8. Nurse staffing

The Committee has received a bi-monthly report on safer nursing and midwifery staffing, noting the pressures on nurse staffing, including those related to patient flow and the need to staff extra capacity areas, and the rates of bank and agency staffing. The Committee has also discussed and supported the national and international recruitment campaigns, and other strategies, including return to practice, which are designed to mitigate on-going pressures on staffing levels.

9. Patient Safety Ombudsman Advisory Panel

The Chair of the Panel has reported to the Committee following each meeting of the Panel and has supported in the context of the Francis report on whistle-blowing, a thorough review of the Trust whistle-blowing arrangements

10. Safeguarding adults and children

The Committee has received reports on the safeguarding adults and children arrangements in place in the Trust and was assured by the partnership working and systems for learning from internal and external reviews, although the Committee has been concerned about levels of safeguarding training.

Professor Malcolm Reed
Chair, Quality and Risk Committee
April 2015