

<b>Meeting:</b>	<b>Brighton and Sussex University Hospitals NHS Trust Board of Directors</b>
<b>Date:</b>	<b>26<sup>th</sup> January 2015</b>
<b>Board Sponsor:</b>	<b>Chair Quality and Risk Committee</b>
<b>Paper Author:</b>	<b>Chair Quality and Risk Committee</b>
<b>Subject:</b>	<b>Quality and Risk Committee</b>

**Executive summary**

The report from the Quality and Risk Committee highlights business discussed at the Committee meetings in November and January with particular reference to: the external review of theatre safety and culture; CQC action plan; progress in the challenged specialties; safeguarding arrangements; nurse staffing levels and the Patient Safety Ombudsman Panel.

<b>Links to strategic objectives</b>	Best and Safest Care ✓
<b>Identified risks and risk management actions</b>	The external review of theatre safety and culture identified a number of risks which are being addressed through an action plan led by the Perioperative Clinical Directorate. Other risks concern mandatory training rates for safeguarding; and actions in relation to the challenged specialities
<b>Resource implications</b>	None
<b>Legal implications</b>	Not applicable
<b>Report history</b>	Not applicable
<b>Appendices</b>	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 26<sup>th</sup> January 2015**

### **Purpose**

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

### **Never Events and Theatres Review**

The Committee discussed the external review of theatre safety and culture at its meetings 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 Medical Director and Chief Nurse will shortly issue a statement of behaviours to all staff as part of the implementation plan.

### **CQC Action plan**

The Committee discussed the action plan following the CQC inspection in May, and received a report on progress with the plan at its meetings in November and January. The report in January, noted the challenges to compliance with regard to the actions concerning patient flow as a consequence of the current pressures across the health and social care system.

### **Safeguarding adults and children**

The Committee received the annual safeguarding children report in November. The Committee was assured by the partnership working in place and systems for learning from internal and external reviews. However compliance with safeguarding training requirements, is insufficient, reflecting broader issues of compliance with mandatory training, the approach to which has been discussed in detail at the Finance and Workforce Committee.

### **Patient Safety Ombudsman Advisory Panel (PSOAP)**

The November meeting of the Panel raised concerns regarding safety and leadership in the Acute Medical Unit (AMU) at the Royal Sussex County Hospital (RSCH) which the Medical Director also addressed in his report to the Committee in January. The January meeting of the Panel discussed in detail a number of individual cases and the lessons to be learned from them.

### **Nurse staffing**

The Committee discussed the pressures on nurse staffing, in a report which will also be presented to the Board, relating to national difficulties in recruitment, the need to staff extra capacity areas, and the rates of bank and agency staffing. The Committee supported the planned next stage of

international recruitment, and other strategies, including return to practice, which are designed to mitigate on-going pressures on staffing levels.

### **Medical Director's report**

The Medical Director updated the Committee on Trust-wide and specialty challenges, with the balance of challenges to patient safety and quality shifting to systemic Trust-wide challenges, rather than those simply within individual services, where good progress has been made in many areas. Those challenges are reported elsewhere at the Board and concern the impact on patient safety and experience of performance in the emergency pathway across the health and social care system, and the implementation of the EPR and Booking Hub change programmes.

### **Safety and Quality Dashboard**

The Committee welcomed the second iteration of the Safety and Quality Dashboard, noting the continued good performance against the mortality metrics and other patient safety indicators within the report.

**Michael Farthing**  
**Chairman Quality and Risk Committee**  
**January 2015**