**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD**

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<th>DATE OF TRUST BOARD MEETING:</th>
<th>4 February 2010</th>
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**COMMITTEE:** Governance and Risk Management Committee  
**CHAIRMAN:** Mr D Tracy, Non-Executive Director  
**DATE OF COMMITTEE MEETING:** 12 January 2010

**RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:**

The Trust Board be requested to note discussions in respect of the:-

- Patient stories (preferably incorporating 'end to end' experience across the healthcare community) to be reported to the Trust Board quarterly from April 2010 (Minute 08/10 refers), and
- planned revisions to the electronic prescribing system (Minute 09/10/1 refers).

**OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/RESOLUTION BY THE TRUST BOARD:**

There were no key issues for consideration by the Trust Board from the Governance and Risk Management Committee.

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<th>DATE OF NEXT COMMITTEE MEETING:</th>
<th>9 February 2010</th>
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Mr D Tracy, Committee Chair  
27 January 2010
RESOLVED ITEMS

01/10 APOLOGIES

Apologies for absence were received from Mr M Lowe-Lauri, Chief Executive.

02/10 WELCOME

The Chairman welcomed Mr A Whalley, Temporary Trust Administrator standing in for Mrs G Belton, to his first meeting of the Governance and Risk Management Committee.

03/10 MINUTES OF THE PREVIOUS MEETING

In respect of Minute 121/09/1 of 15 December 2009 (Presentation from Musculo-Skeletal Services), the Trust Administrator confirmed that bullet point (vi) on page 5 made reference to the ‘Quality Schedule’ target and not the ‘CQUIN’ target as resolved.

Resolved – that (A) the Minutes of the Governance and Risk Management Committee meeting held on 15 December 2009 (paper A) be confirmed as a correct record, and

(B) the contents of the associated Governance and Risk Management Committee action sheet from the same meeting (paper A1) be received and noted.
04/10 MATTERS ARISING FROM THE MINUTES

04/10/1 Patient Safety Report (Minute 134/09/4)

The Director of Safety and Risk distributed a paper which detailed the themes and trends in formal complaints received within Musculo-Skeletal Services in Q2 2009. She advised that the complaints were categorised per 100 patient episodes and by type and location. The complaints largely related to ‘process’ issues and it was noted that there had been an increase in complaints relating to rheumatology. The Acting Medical Director reported that he was aware of some complaints arising as a result of the controls put around visiting access due to the swine flu pandemic. The number of verbal complaints and complaints relating to waiting times were highlighted and, given the importance of such issues, it was agreed that the Director of Safety and Risk should undertake further investigation into the complaints statistics provided by Musculo Skeletal Services, to explore whether common themes could be identified for more critical analysis (thus facilitating service improvement) and report to the next meeting of the Governance and Risk Management Committee on 9 February 2010.

Resolved – that the Director of Safety and Risk be requested to undertake further investigation into the complaints statistics provided by Musculo-Skeletal Services, to explore whether common themes could be identified from more critical analysis (thus facilitating service improvement), and report to the meeting of the Governance and Risk Management Committee on 9 February 2010.

DSR/TA

04/10/2 Directorate Risk Registers (Minutes 133/09/1, 133/09/4 and 134/09/2)

The Director of Safety and Risk advised that she would ensure that she had received the updated risk registers for Musculo-Skeletal Services, Surgical Services and Cardio-Respiratory Services by 31 January 2010 and that she would then prepare an analysis for discussion at the meeting of the Governance and Risk Management Committee on 9 February 2010.

Resolved – that the Director of Safety and Risk be requested to ensure receipt of all revised Clinical Directorate risk registers by 29 January 2010, and prepare an accompanying analysis for discussion at the meeting of the Committee on 9 February 2010.

DSR/TA

04/10/3 Care Quality Commission (CQC) Registration (Minute 135/09/1)

The Director of Clinical Quality confirmed the process for registration with the CQC applicable to Trusts, reiterated the timetable for registration and confirmed that the submission deadline was 29 January 2010. Given the importance of this issue, the Director of Clinical Quality was requested to provide the Committee with an update on the CQC registration process and the evidence required to support the new standards at the meeting of the Governance and Risk Management Committee to be held on 9 February 2010.

Resolved – that the Director of Clinical Quality provide an update of the CQC registration process and of the evidence required to support the new standards at the meeting of the Committee to be held on 9 February 2010.

DCQ/TA

05/10 SAFETY

05/10/1 Presentation from the Facilities Directorate
The Director of Facilities and the Facilities Senior Statutory Compliance Manager presented paper B which included information regarding the Directorate background and internal and external reporting, health and safety information, complaints response data, incidents, the risk register and risk management methods. The Directorate had responded to 100% of the alerts issued by the central alerting system within the required timescale in 2009. They advised that the Facilities Directorate was responsible for the non-clinical services undertaken to support patient care and explained that the Directorate managed both physical and reputational risks through specialist multidisciplinary committees reporting to the sub committees of the Trust Board. These committees and their reporting mechanisms were clarified. The Directorate’s three top risks were indicated and the risk management approaches adopted by the Directorate – to manage, monitor, audit, review and obtain external validation – were confirmed and an example was given to illustrate the Directorate’s effectiveness. The Directorate had embedded risk management into its activities and had this as an agenda item at the monthly Facilities Directorate Management Board meetings. In addition, the Directorate had a monthly Risk Management Group which reported to the Facilities Directorate Management Board. Several examples of reviewed risks on the Directorate Risk Register were given including that of ‘wandering’ patients and the related issue of access/egress control arrangements and, after discussion, it was accepted that this was a high priority to resolve. The Chief Operating Officer / Chief Nurse agreed to continue to work with the Director of Facilities to assess the risk of ‘wandering patients’ with a view to submitting a report to a future meeting of the Investment Management Committee and to seek any additional investment necessary to strengthen access/egress control arrangements.

**Resolved** – that the Chief Operating Officer/Chief Nurse and the Director of Facilities continue their work jointly to assess the risk of ‘wandering patients’, with a view to submitting a report to a future meeting of the Investment Management Committee and seeking any additional investment deemed necessary to strengthen access/egress control arrangements.

05/10/2 Improving Safe Medication Practices across UHL

The Chief Pharmacist presented paper C, a report to update the Committee against the recommendations to improve safe medication practices for children, as outlined in a report presented at the Governance and Risk Management Committee on 12 May 2009 (Minute 40/09/2 refers). She advised that the improvement programme was focused on delivering improvements in medicines management across all areas of the Trust and was not restricted to children. The report noted that continued progress had been made and that there was strong clinical engagement on this agenda. There had been no further 10 x medication errors in Children’s Services but there had been a number of near misses (prevented safety incidents) since September 2009, each of which had been intercepted prior to administration.

The Chief Pharmacist reported that the majority of actions in the action plan were completed or on target for completion, but that there were several areas where progress was slower than anticipated (as detailed in the report). Plans were in place to address this, including an internal and external communications campaign. Significant improvements in compliance with prescribing and administration standards in improving medication safety standards in adults had been achieved and there had been a step increase in medical leadership in supporting junior doctors. Although there had been three 10 x error incidents in adults since September 2009 and four near misses (prevented safety incidents), each of these had been intercepted prior to administration. She advised that an Electronic Prescribing and Medication Administration (EPA) system was being procured with a ‘go live’ for Phase 1 areas planned for October 2010 but which would take three years to be deployed. The ways in which the Trust planned to share its work at national level and to undertake
research into the strategies taken were outlined.

Resolved – (A) the report be received and noted, and

(B) the Chief Pharmacist (in conjunction with the Chief Operating Officer / Chief Nurse on point (ii) below) be requested to provide the following information to the Governance and Risk Management Committee on 9 February 2010:-

(i) a presentation to establish the scope for accelerating the action plan (and any additional resources required as a result), and

(ii) reconciliation of the management report and the Chief Pharmacist’s report regarding 10 x medication errors.

05/10/3 Patient Safety Report

The Director of Safety and Risk presented paper D, which updated the Committee on key safety issues being considered nationally and within the Trust. A summary of serious untoward incidents reported during December 2009 was tabled at the meeting.

The new ‘Essential Standards of Quality and Safety’ published by the Care Quality Commission (CQC) in December 2009 required the Trust to evidence that patients were being treated safely in safe and suitable environments, by trained and experienced staff using safe and suitable equipment. This safety thread ran through all 28 “outcomes”, with service providers being required to review, monitor and have confidence in the quality and services provided. She advised of the number of incidents reported in the quarter 2 report of the National Reporting and Learning System (RLS) arm of the National Patient Safety Agency (NPSA) and recapped the five interventions of the NPSA implemented within the Trust. The actions for each intervention were monitored by the Patient Safety First Project Board (now consolidated into the NPSA) and had become a key measure for safety. The quality and safety indicators for reporting and monitoring and being part of the ongoing contract negotiations for NHS services with Primary Care Trusts for 2010/11 were indicated.

It was agreed that the Director of Safety and Risk would provide an update on progress (particularly regarding the strengthening of evidence between collecting statistics data and resulting improvements in service) at the next meeting of the Committee to be held on 9 February 2010, that the Chief Operating Officer / Chief Nurse would continue to review the situation in the Obstetrics Unit given the increasing demand for its services and to report back to a future meeting of the Committee and that the Acting Medical Director would provide a formal progress report on the fractured neck of femur work at the meeting of the Governance and Risk Management Committee on 9 February 2010.

Resolved – that (A) the Director of Safety and Risk be requested to provide an update on progress on this report (particularly regarding the strengthening of evidence between collecting statistics data and resulting improvements in service), to the meeting of the Governance and Risk Management Committee on 9 February 2010;

(B) the Chief Operating Officer/Chief Nurse be requested to continue to review the situation in the Obstetrics Unit given the increasing demand for its services and to report back to a future meeting of the Governance and Risk Management Committee accordingly, and

(C) the Acting Medical Director provide a formal progress report on the fractured neck of femur work to the Governance and Risk Management Committee on 9 February 2010.
Vetting and Barring Scheme

The Director of Human Resources and the HR Shared Services Manager presented paper E which provided an overview of the Vetting and Barring Scheme (‘the Scheme’) launched in October 2009 but being rolled out over a five year period. The purpose of the Scheme was outlined and the two ‘barred lists’ managed by the Independent Safeguarding Authority (ISA) were explained. The application process, the costs of registering with the ISA and the five phases of the roll out programme were noted.

Particular discussion took place regarding the following:

(a) 70% - 80% of staff had been required to have Criminal Records Bureau checks and these staff would need to be registered with the ISA. It was intended that the Trust should pay for these registrations;  
(b) from July 2010, all new entrants to roles regularly working with vulnerable groups and those switching jobs would be able to register with the ISA and be checked. It was agreed that a further update report would be presented to the Committee in advance of this July 2010 roll-out milestone;  
(c) whether there were any risks to the Trust in introducing the ISA registration process;  
(d) the requirement for auditing of the registration process. It was advised that pre-employment checks were audited already and members noted that registration with the ISA would form part of the audit controls; and  
(e) the extent of resources required to carry out the ISA register checks. It was confirmed that the resources required had been noted.

The Committee also noted the following key points:- (i) from November 2010, all new entrants to regulated activity (including in a supervisory capacity) involving working or volunteering with children and / or vulnerable adults and existing staff changing jobs would be legally required to register with the ISA before they took up an appointment and confirmation of registration must be obtained beforehand;  
(ii) up to five years (to 31 July 2015) was being given to ensure that all existing employees and volunteers were registered with the ISA. For Trust volunteers, registration with the ISA and CRB checks were free, and  
(iii) the Director of Human Resources would provide a further update report to a future meeting of the Committee ahead of the July 2010 roll-out milestone.

Resolved – that the Director of Human Resources be requested to provide a further update report on the Vetting and Barring Scheme to a future meeting of the Governance and Risk Management Committee ahead of the July 2010 roll-out milestone.

Summary Results of the Human Tissue Authority Inspection of the Leicester Bone and Tissue Bank on 15 and 16 September 2009

The Director of Clinical Quality presented paper F which summarised the results of the Human Tissue Authority’s (HTA) Inspection of the Leicester Bone and Tissue Bank (‘the Bank’), the Bank’s supporting draft action plan and a full copy of the HTA’s report. The HTA was satisfied that the Bank was suitable to be licensed for the purposes specified and it was noted that the inspection had resulted in HTA guidance.
only and not the application of any conditions to the licence. The HTA had
commended the Bank’s staff for their work commitment since the last inspection and
requested that examples of the Trust’s policies and procedures be circulated to as
best practice to tissue banks nationwide. It was noted that the ongoing monthly
programme ensured that all policies, procedures and documentation as mentioned in
the HTA’s ‘advice and guidance’ were scheduled for review on a rolling twelve
months schedule and, as this followed a twelve month plan, some but not all of the
reviews had been completed at the time of the inspection. The Bank was to continue
to progress the HTA’s guidance notes ahead of the HTA’s next visit, anticipated in
September 2010.

Resolved – that the contents of this report be received and noted.

07/10 RISK

07/10/1 Swine Flu Pandemic Update

The Chief Operating Officer / Chief Nurse advised verbally as to where the Trust was
positioned in relation to the national bar set for staff vaccination and suggested that
as the anticipated second wave of the pandemic had not happened, this had altered
people’s behaviour in relation to vaccination.

Resolved – that this verbal information be noted.

08/10 PATIENT EXPERIENCE

08/10/1 Patient Experience Group

The Director of Clinical Quality reported that the January 2010 meeting of the Patient
Experience Group had been cancelled but that an extraordinary meeting had been
called for February 2010.

In discussion on this item, members:-

(i) noted that the Director of Safety and Risk, the Director of Clinical Quality, the
Acting Medical Director, Senior Safety Manager (Clinical Risk and Complaints)
and Acting Head of Service had met to discuss the format for patient stories,
which cover patients’ ‘end to end’ experience across the healthcare community,
picking out key themes and interventions;

(ii) discussed the benefits of patient stories not being limited to a video format, to
enable the stories of patients who did not wish to be videoed to be captured. The
benefits of patients’ diaries were discussed; and

(iii) noted that many patients had a compelling message with a strong impact.
Members also noted the power of patients telling their own stories, both positive
and negative.

It was agreed that the Acting Medical Director, the Director of Clinical Quality and
Director of Safety and Risk would commence reporting on patient stories (preferably
incorporating ‘end to end’ experience across the healthcare community) to the Trust
Board on a quarterly basis from April 2010.

Resolved – that the Acting Medical Director, the Director of Clinical Quality and
Director of Safety and Risk commence reporting on patient stories (preferably
incorporating ‘end to end’ experience across the healthcare community) to the Trust
Board on a quarterly basis from April 2010.

AMD/ DCQ/ DSR/ TA
Quality and Performance Report – Month 8

Members received and noted the contents of paper G which provided a month 8 position statement against performance indicators encompassing quality, HR, finance, commissioning and operational targets.

Resolved – that the contents of this report be received and noted.

09/10 QUALITY

Nursing Metrics

The Chief Operating Officer / Chief Nurse presented her ‘Setting the Scene, Care Metrics’ presentation as background to support both papers H (which updated the Committee on progress in applying the indicators making up the nursing metrics as the key criteria for measurement of the quality of nursing care) and G (Minute 08/10/2 above). In discussion on this item, members:

(a) noted the detail of the indicator criterion making up the risk indicator and the need for this to be applied consistently across the three hospital sites;
(b) made note of the need for there to be one consistent risk assessment record for completion across the three hospital sites and for the scope of such an assessment to be under the control of a central control group;
(c) noted from the Quality and Performance Report the levels of quality and performance required to be satisfactory;
(d) noted that all ward areas on the three hospital sites would be encompassed by 31 March 2010, and
(e) considered the reliance on technology to aid data collection and report transference for UHL’s electronic prescribing support. Discussions continued ahead of a planned revision to the electronic prescribing process. It was agreed to highlight this issue to the Trust Board on 4 February 2010 through these Minutes.

In concluding the discussion on this item, it was agreed that the Director of Clinical Quality would prepare a draft UHL Quality Strategy for discussion by the Governance and Risk Management Committee at its meeting on 9 February 2010.

Resolved – that (A) the resolution be noted,

(B) the Chief Operating Officer / Chief Nurse be requested to provide a report on the roll-out of the nursing metrics to the Committee in 3 months’ time (April / May 2010), and

(C) the Director of Clinical Quality be requested to submit the draft UHL Quality Strategy to meeting of the Governance and Risk Management Committee on 9 February 2010, and

(D) planned revisions to the electronic prescribing system be highlighted to the Trust Board on 4 February 2010 via these Minutes.

ITEMS FOR INFORMATION

Finance and Performance Committee Minutes

The Committee received and noted the Finance and Performance Committee Minutes from the meeting held on 26 November 2009 (paper I).
Resolved – that the position be noted.

11/10 ANY OTHER BUSINESS

There were no items of Any Other Business.

12/10 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board at its meeting on 4 February 2010:-

- Patient stories (preferably incorporating ‘end to end’ experience across the healthcare community) to be reported to the Trust Board quarterly from April 2010 (Minute 08/10 refers), and
- the planned review of electronic prescribing support (Minute 09/10/2 refers)

13/10 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Tuesday 9 February 2010 from 8.00am in Conference Rooms 1A and 1B, Gwendolen House, Leicester General Hospital.

The meeting closed at 11.10am.

Adrian Whalley
Temporary Trust Administrator