Trust Board paper K

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 1 December 2011

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 27 October 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 3 November 2011.

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

There are no specific recommendations for the Trust Board from the Governance and Risk Management Committee.

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

- **the detailed review of falls (Minute 96/11/5 refers);**
- **dashboard of underperforming wards (Minute 97/11/1 refers), and**
- **progress in relation to medical metrics (Minute 97/11/3 refers).**

DATE OF NEXT COMMITTEE MEETING: 25 November 2011

Mr D Tracy
25 November 2011

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 27 OCTOBER 2011 AT 1:15PM IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Mr M Lowe-Lauri – Chief Executive
Mr P Panchal – Non-Executive Director
Mrs E Rowbotham – Director of Quality, NHS LCR (non voting member)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Mr J Braybrooke – Orthopaedic Consultant (for Minute 95/11/1)
Dr B Collett – Associate Medical Director, Clinical Effectiveness (on behalf of Dr K Harris, Medical Director)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Ms H Killer – Children's CBU Manager (for Minute 96/11/1)
Mrs H Majeed – Trust Administrator
Ms H Poestges – Researcher, KCL (observing)
Mrs C Ribbins – Director of Nursing/Deputy DIPAC (also representing the Chief Operating Officer/Chief Nurse)
Prof D Rowbotham – Chair of the #NOF Steering Group (for Minute 95/11/1)
Mr P Walmsley – Divisional Manager, Acute Care (observing) (until part-Minute 96/11/3)
Mr D Yeomanson – Divisional Manager, Women's and Children's (for Minute 96/11/1)

ACTION

RESOLVED ITEMS

93/11 APOLOGIES

Apologies for absence were received from Mr M Caple, Patient Adviser; Dr K Harris, Medical Director and Mrs S Hinchliffe, Chief Operating Officer/Chief Nurse.

94/11 MINUTES

Resolved – that the Minutes and action sheet (papers A-A2) from the meeting held on 29 September 2011 be confirmed as a correct record.

95/11 MATTERS ARISING REPORT

The Committee Chair confirmed that the matters arising report (paper B) both highlighted the matters arising from the most recent meeting and provided an update on any outstanding GRMC matters arising since October 2009.

Resolved – that the matters arising report (paper B) be received and noted.

95/11/1 Report by Director of Safety and Risk

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

95/11/2 Progress Report on Fractured Neck of Femur (#NOF)

Further to Minute 50/11/1 of 30 June 2011, paper C from the Chair of the #NOF Steering Group outlined the current performance in respect of the #NOF theatre target of 36 hours to theatre from being diagnosed or admitted in addition to the regional performance data (appendix 1 refers) from the National Hip Fracture Database (NHFD) 2011. The Chair of the #NOF Steering Group advised that performance was broadly on track but it was not consistent and had now plateaued. He re-iterated that the team were looking into ways to further improve performance, however this had proved challenging. He was unsure whether facilities were being used fully and efficiently. The reduction in performance in some months was specifically due to annual leave taken but mechanisms had now been put in place for cross cover to prevent this from happening again. Additional theatre capacity and staff through the Theatres Transformation Project might prove useful to cope with day to day peaks and bank holidays.

There was a need to ensure consistent postoperative assessments on the wards in order to sustain performance. The performance against best practice tariff was also not exceptional.

The NHFD report had highlighted the key improvements but had also emphasised several areas that needed significant improvement. The Orthopaedic Consultant advised that performance in general had been good, however he highlighted that there were inefficiencies in weekend hip lists. Members were advised that if there was a significant increase in trauma cases in addition to #NOF cases, then additional lists were a possibility, however, availability of staff at short notice was an issue. Discussions were taking place with Ms E Ryan, Senior Responsible Officer, Theatres regarding efficient use of theatres and informing the #NOF team if there was any under-utilisation.

UHL was one of the top three hospitals in respect of the total #NOFs seen per annum noting that coping with the peaks of #NOF admissions was a pressure which few other hospitals faced. In response to a query, it was noted that if a like to like comparison was made, then UHL was well above the national average. If data was scrutinised, then the Trust performed well for the services that it provides. The Head of Operations queried whether the option of displacing electives had been explored – in discussion on this, it was suggested that this would be dealt with outside the meeting.

The Director of Communications and External Relations re-iterated that in spite of the number of improvements being put in place since April 2010, UHL's mortality rate in respect of this indicator had remained the same in 2009-10 and 2010-11. In response to this, it was noted that the mortality database was available as a funnel plot and UHL was plotted in the middle. The average mortality rate for #NOF patients who died within 30 days of operation was 8% and UHL's mortality rate was 7.5% from September 2010 to September 2011.

The Committee Chair queried whether due to the importance being given to #NOF cases, if it had a detriment effect on other cases – in response, members were advised that hip lists saw a breach due to this but there was not a huge detriment to the other trauma cases. The Committee Chair noted the need for consideration to be given to the current working in relation to care of patients with #NOF to ascertain whether it should be proceeded in the same way or whether it could be dealt with differently and provide an update at the GRMC meeting on 26 January 2012. **#CNOF SG**

Following departure of the presentation team, the Associate Medical Director stressed that the work of the #NOFSG should not be under-estimated. She re-iterated that although a change in mortality had not been seen, there might have been an improvement in morbidity. The Director of Quality, NHS LCR noted the need for current position to be maintained rather than seeing a dip in performance. The Director of Nursing commented that the working of the #NOFSG had been exceptional. The Director of Clinical Quality noted that the MDT working had broken down barriers and the working group was also monitored through the Clinical Quality Review Group.

Resolved – that (A) the contents of paper C be received and noted, and

(B) the Chair of the #NOF Steering Group be requested to give consideration to the current working in relation to care of patients with #NOF to ascertain whether it should be proceeded in the same way or whether it could be dealt with differently and provide an update at the GRMC meeting on 26 January 2012. **#CNOF SG**

96/11 SAFETY AND RISK

96/11/1 Report by the Associate Medical Director (on behalf of the Medical Director)

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

96/11/2 Critical Safety Actions – Relentless Attention to EWS Triggers and Actions

The Associate Medical Director presented paper E, an update on relentless attention to EWS trigger which was one of the five critical safety actions. Overall, UHL's compliance was 99.2% in relation to clinical observations being undertaken and recorded for all patients, as appropriate. However, within the scorecard some EWS incidents had been identified and further review of this had indicated that this was recurrent in the same area. There was a need for CBUs to ensure that actions agreed following an incident were completed. In discussion, the Director of Quality, NHS LCR suggested that the embedding of RCA action plans be an agenda item for the next UHL/PCT joint governance meeting. **DQ, NHS LCR/ DSR**

Members expressed concern that only 50% of nurses had currently completed VITAL training relating to EWS usage and escalation process. In response to a query on the reason for EWS not being appropriately escalated, it was noted that there was a range of reasons and the importance and standardisation of medical and nursing handover was being addressed collaboratively to ensure that a basic minimum of patient related detail including EWS triggers was communicated and reviewed on a regular basis. There was also a need for the junior doctor to review the patient on a timely basis and escalate to a senior appropriately, as required. The current EWS referral and escalation pathway had been recently changed to improve compliance and senior involvement in patient related decision making. Members were advised that this would be implemented in January 2012 following distribution of new paperwork.

The Director of Corporate and Legal Affairs noted that attendance of nurses was monitored but queried whether the attendance of doctors at training sessions was tracked - in response, members were advised that the specialty specific training/learning sessions were recorded within the CBUs, however, a Trust-wide tracking system was not in place. It was agreed that this would be discussed by the QPMG in December 2011. **DSR/ AMD**

The Committee Chairman suggested that an update on how each of the critical safety actions would be tracked be provided at the GRMC meeting in early January 2012. **DSR/ AMD**

Resolved – that (A) the contents of paper E be received and noted; **DQ, NHS LCR/ DSR**

(B) the embedding of RCA action plans be an agenda item for the next UHL/PCT joint governance meeting;

(C) the Director of Safety and Risk and the Associate Medical Director be requested to lead a discussion on tracking attendance of medical staff at training sessions at the QPMG meeting in December 2011, and **DSR/ AMD**

(D) the Director of Safety and Risk and the Associate Medical Director be requested to provide an update at the GRMC meeting on 4 January 2012 on how each of the critical safety actions would be monitored. **DSR/ AMD**

96/11/3 Patient Safety Report

Paper F from the Director of Safety and Risk advised the GRMC of the Information Centre for Health and Social Care Data on written complaints in the NHS 2010-11, the DoH 'Implementing a Duty of Candour', waiting times and cancelled operations in Planned Care, learning from SUIs, ongoing NPSA alerts with an expired deadline as of September 2011, the SUIs reported in September 2011 and 60-day root cause analysis (RCA) performance. Section 2.4 of paper F provided data from the Information Centre in respect of the percentage change in complaints received within the East Midlands - UHL had seen a 9.7% increase. The report did not provide complaint rates by activity, hence it could not be used as a benchmarking tool. However, the Director of Safety and Risk highlighted that some of the Trusts listed in the report did not accept complaints if they were 12-14 months after the date of the incident but UHL accepted all complaints and did not specify a time period - members were advised that this might be one of the reasons for UHL's increase in the number of complaints received. The Director of Safety and Risk advised that she had been in discussion with some Trusts which had had a decrease in complaints and it was noted that these Trusts resolved issues within 24 hours of receiving a complaint and therefore the complaint was not required to be logged as a formal complaint. Ms J Wilson, Non-Executive Director queried the actions that UHL had put in place to resolve issues/complaints in time (within 24 hours), it was noted that this was an item for discussion at the QPMG meeting in November 2011. **DSR**

In discussion, the Head of Operations noted the need for appropriate escalation to Divisions if any behavioural aspects of staff prompted patients to log a complaint. The Director of Nursing re-iterated that Divisions would need to challenged on whether the Caring @ its Best 10 point action plan was being appropriately followed. In many cases, complaints could be avoided if the patients/families were appropriately informed/communicated.

The Committee Chairman highlighted that the data from the Information Centre did not provide a 'like for like' comparison and hence it was not a useful benchmarking tool. He suggested that complaints details be included within the ward dashboards and was advised that this had just commenced.

The consultation process on the Government's Duty of Candour proposals (section 3 of paper F refers) would run until 2 January 2012. This document had been sent to all Divisional Directors for discussion within CBUs and the Director of Safety and Risk advised that it would be further considered at a future QPMG meeting. **DSR**

Further to Minute 87/11/1 of 29 September 2011, the Director of Safety and Risk had undertaken a review of the complaints received in the Planned Care Division since April 2010 for both waiting times and cancelled operations. Within some specialties, waiting times had increased to greater than 15 weeks - this was now being addressed within the Division. The reason for cancelled operations included non-availability of ITU beds, staffing shortages, bed capacity issues, lack of equipment and administrative errors. It was suggested that a deep-dive would be undertaken when the Division would be attending the GRMC meeting to present a report on their complaints performance. The Associate Medical Director advised that the Royal College of Surgery had published a report on emergency surgery and the Medical Director had established a task and finish group to review the findings.

The Associate Medical Directors (Clinical Effectiveness and Education) and the Director of Safety and Risk would be undertaking an educational programme for medical staff across the Trust whereby case studies would be presented to learn from SUIs and other incidents. In particular, the issue of missed diagnosis would feature in junior medical staff teaching and in Consultant meetings as well as these SUIs being discussed in specialty mortality and morbidity meetings.

Appendix 1 provided a breakdown of the outstanding NPSA alerts in the Trust and estimated timescales for completion.

A total of 9 SUIs were escalated during the month of August 2011 (3 related to patient safety incidents, 5 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3&4) and 1 related to Healthcare Acquired Infections). In respect of SUI reference: 2011/18385, Ms J Wilson, Non-Executive Director noted the need for assurance that hourly ward rounds had been embedded in the ward where the incident had occurred – the Director of Nursing agreed to follow-up this. The Director of Communications and External Relations noted the need for appropriate escalation of SUIs and information of these to be provided to appropriate staff so that timely action could be taken - a top down approach was suggested. **DoN**

Resolved – that (A) the contents of paper F be received and noted;

(B) the Director of Safety and Risk be requested to ensure that the data from the Information Centre for Health and Social Care on written complaints in the NHS in 2010-11 be shared with the QPMG in November 2011 and Divisions be required to provide an update on targeted actions to reduce complaints; **DSR/ TA**

(C) the Director of Safety and Risk be requested to ensure that the consultation process on the Government's Duty of Candour proposals be considered at a future Quality and Performance Management Group meeting, and **DSR**

(D) the Director of Nursing be requested to follow-up SUI reference (2011/18385) to ensure that hourly ward rounds had been embedded in the ward where the incident had occurred. **DoN**

96/11/4 Quality and Safety Risk Assurance Process for CIP Schemes - Divisional monitoring arrangements

The Director of Nursing advised that the safety and quality issues were discussed at the monthly confirm and challenge sessions and weekly metrics meetings. The Divisions were required to risk assess their CIP schemes. The Director of Corporate and Legal Affairs confirmed that the Project Management Office concept had been accepted by the Executive Team and the Chief Operating Officer/Chief Nurse and the Director of Strategy had been tasked to mobilise it.

Resolved – that the position be noted.

96/11/5 Detailed Review of Falls

The Director of Nursing presented paper G, a report on a detailed review of UHL inpatient falls. She drew members' particular attention to the following points:-

(a) through comparative data from other organisations and national NPSA data, it had become apparent that UHL was not an outlier in terms of the number of falls recorded in the organisation;
(b) the majority of patients (95%) had an appropriate risk assessment and care plan. The assessment and care planning documents met the best practice national guidance;
(c) root cause analysis of areas where there had been a high incidence of falls would provide a framework for prioritisation of action, in relation to patient, environment and staff factors, and
(d) further actions needed to be put in place to ensure robust reporting via Datix for all fractures and head injuries in order to ensure accurate data across the organisation.

In discussion on the inpatient falls report the GRMC noted:-

- a query from Professor D Wynford-Thomas, Non-Executive Director, as to whether there was an irreducible minimum in the number of falls. In response, it was noted that this had been previously discussed and it would be not be possible to fix a minimum

number;

- the Director of Corporate and Legal Affairs suggestion on the development of a post falls protocol - to review the fall after it had happened in order to ascertain if there were any aspects that could have been avoided/included that would have prevented the fall, and
- a comment from the Committee Chairman that the table on page 5 of the paper provided assurance that although UHL reported a high number of patient safety incidents, the percentage of these relating to patient accidents (which were predominantly falls) was fewer than other Trust in the East Midlands.

Responding to a query, the Director of Nursing agreed to give consideration to other areas (in addition to pressure ulcers and falls) which required a detailed review at GRMC meetings. **DoN**

The Committee Chairman suggested that the report on the review of pressure ulcers and falls be provided to the Director of Quality, NHS LCR (as a means of assurance). A further update on inpatient falls would be provided to the GRMC in February 2012. **DoN** **DoN**

Resolved – that (A) the contents of paper G be received and noted;

(B) the Director of Nursing be requested to give consideration to other areas (in addition to pressure ulcers and falls) which required a detailed review at GRMC meetings; **DoN**

(C) the Director of Nursing be requested to share the pressure ulcers and falls review report with the Director of Quality, NHS LCR in order to provide assurance; **DoN**

(D) the Director of Nursing be requested to continue close monitoring of falls incidence and provide a further update to the GRMC meeting in February 2012, and **DoN/ TA**

(E) the GRMC Chair be requested to highlight the assurance received from the work to date on falls, to the 3 November 2011 Trust Board via the GRMC Minutes. **GRMC Chair**

96/11/6 Report by the Director of Nursing

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

9711 QUALITY

97/11/1 Nursing Metrics and Extended Nursing Metrics

Paper H summarised progress against the nursing metrics for the period August 2009-September 2011. All of the nursing metrics continued to maintain positive or developing performance, with improvements seen across most ward areas in respect of patient discharge. Work was now underway to refine the patient discharge metric further, with a particular emphasis on early prescribing of TTOs noting that the September 2011 performance was reported as 82%. Paper H1 detailed performance in respect of the extended nursing metrics now in place within eight specialist areas within the Trust.

The Director of Nursing tabled anonymised versions of dashboards of the six worst performing wards. Three of these were worst-performing in respect of the metrics and the other three of the wards were worst-performing in relation to their patient polling results, but only one of these six wards correlated in both these aspects.

It was noted that actions had been put in place to resolve issues concerning these wards and formal letters had been sent to the Ward Sisters. The wards under-performing in relation to patient experience were predominantly in the Medicine CBU. The Head of Patient

Experience had now been appointed as the Matron of these wards and a Lead Nurse vacancy had also been filled.

In respect of the wards which had been under-performing in the nursing metrics, re-audit of the metrics was being undertaken on a weekly basis and the wards outside the Medicine CBU currently scored 100%. One of the wards which had been underperforming had in fact transferred sites and staff were undergoing a management of change process.

The Director of Communications and External Relations queried that only one of the wards correlated in respect of being underperforming in both metrics and patient polling and he expressed uncertainty on whether the data was correct – the Director of Nursing advised that only part of the data set was being considered. The Committee Chairman expressed an interest in seeing the rating of the worst performing wards in relation to how they fell within the 'patient experience' category. He suggested that the dashboard of underperforming wards be presented to the GRMC every six months.

DoN

DoN

Resolved – that (A) the update on the nursing and extended nursing metrics be noted;

(B) the update on the six underperforming wards be noted;

(C) the Director of Nursing be requested to rate the worst performing wards in relation to how they fell within the 'patient experience' category; DoN

(D) the Director of Nursing be requested to ensure that the dashboard of the six worst performing wards be presented to the GRMC meeting every 6 months starting from April 2012, and DoN/ TA

(E) the GRMC Chair be requested to highlight the dashboard of underperforming wards, to the 3 November 2011 Trust Board via the GRMC Minutes. GRMC Chair

97/11/2 Quality Finance and Performance Report – Month 6

Papers I and I1 detailed the quality, finance and performance report and heat map for month 6 (month ending 30 September 2011). The Director of Nursing particularly noted:-

(i) despite revised rotas and triage facilities in both AMU and ED, September Type 1 and 2 was 89.8% and including UCC was 92%. ED performance and Emergency Care Network targets would be addressed in the Emergency Care Transformation report;

(ii) no cases of MRSA were reported with a year to date position of 4, and

(iii) appraisal rates had increased slightly to 88.7% from 87.7% last month.

The Associate Medical Director advised that UHL currently used the CHKS 'RAMI' for monitoring its risk adjusted mortality rate. RAMI only included in-hospital deaths. The newly published Summary Hospital Mortality Index (SHMI) included 'deaths within 30 days of discharge' as well as in-hospital mortality and did not exclude any palliative care patients (these patients were not included in the CHKS 'RAMI' model). UHL's RAMI for 2010-11 was 86 and the SHMI for the same period was 106, which was within expected limits when using 95% confidence intervals. The review of UHL's RAMI as reported by CHKS had led to improvements in processes for clinical coding and also coding of patient activity. Specialties would be using the data to support their mortality and morbidity review process. The Associate Medical Director advised that a further report on SHMI would be provided to the GRMC in November 2011.

MD

Resolved – that (A) the quality and performance report and divisional heat map for month 5 (month ending 31 August 2011) be noted, and

(B) the Medical Director be requested to present a further report on SHMI at the GRMC meeting in November 2011. **MD/TA**

97/11/3 Medical Metrics

The Associate Medical Director presented paper J, an update on progress in the development and implementation of medical metrics and engagement with Consultants and trainee doctors. The medical metrics was a new concept for many doctors and implementation would improve quality, safety and effectiveness of medical care. It was suggested that it would be preferable if medical metrics were monitored at an individual doctor level rather than as a team/ward.

The data collection needed to be stream-lined and robust. Table 1 of the paper provided a list of possible medical metrics. In relation to this list, Professor D Wynford-Thomas, Non-Executive Director suggested that some of the indicators in the effectiveness section would fit more appropriately in the clinical outcomes section. The Director of Communications and External Relations suggested that Implementation of Patient Reported Outcome Measures (PROMs) and Clinical Reported Outcome Measures (CROMs) also be included. In addition to the patient survey questions listed within the 'Patient Experience' section, he suggested that the question relating to 'Have you been treated with dignity and respect' also be included.

The Director of Corporate and Legal Affairs queried whether the Trust would be able to benchmark itself and suggested that other Trusts be contacted to ascertain whether they had systems in place to monitor medical metrics. Mr P Panchal, Non-Executive Director suggested that monitoring indicators of other professionals (i.e. barristers) also be considered. Members also suggested that 'at-a -glance' dashboards and 360˚ appraisals might also prove useful. **AMD**

Resolved – that (A) the contents of paper J be received and noted;

(B) the Associate Medical Director be requested to contact other Trusts (e.g. Addenbrookes Hospital) to ascertain whether they had systems in place to monitor medical metrics, and **AMD**

(C) the GRMC Chair be requested to highlight the work to date on medical metrics, to the 3 November 2011 Trust Board via the GRMC Minutes. **GRMC Chair**

97/11/4 Deloitte Action Plan - Progress

The Director of Clinical Quality presented paper K, an update on the implementation of recommendations following the review of quality governance arrangements by Deloitte in March 2011. The action plan had been updated (appendix 1 refers). Progress had been made against all the recommended actions with no 'red' ratings. A number of the actions were still rated 'amber' but this was because these actions required regular review as part of routine governance processes.

In response to a query in relation to recommendation 33, it was noted that action relating to a Trust Board development session on patient experience had been superseded by the presentation of a 'patient story' which was scheduled on the agenda for the Trust Board meeting in November 2011.

The Director of Corporate and Legal Affairs advised that effective arrangements for monitoring and continually improving the quality of healthcare of UHL's patients would be considered by the Executive Team and the action plan should be embedded. This would also be re-visited as part of the Monitor quality governance arrangements. As part of the FT journey, the quality governance framework would need to be undertaken at a granular level and there was a need to continue to meet the requirements.

Resolved – the contents of paper K be received and noted.

97/11/5 Quality Account 2010-11 Update and Plans for 2011-12

Paper L provided an update on:-

(a) the month 6 progress in relation to priorities that were set in 2011-12;

(b) the key findings from the dry-run of external assurance of QA that was undertaken on the 2010-11 accounts by the Trust's external auditors, KPMG, and

(c) lessons learned from the 2010-11 QA and the draft project plan for production of 2011-12 QA.

The Director of Clinical Quality advised that the draft quality account 2011-12 would be presented to the GRMC meeting in February 2012. **DCQ**

Resolved – that (A) the contents of paper L be received and noted, and

(B) the Director of Clinical Quality be requested to present the draft quality account 2011-12 to the GRMC in February 2012. **DCQ/ TA**

98/11 PATIENT EXPERIENCE

98/11/1 Quarter 2 (2011-12) Patient Experience Report

The Director of Nursing presented paper M, an update on the patient and family experience feedback plan for quarter 2 of 2011-12.

The patient and family experience feedback plan included high level information on patient experience feedback trends and analysis. The patient experience survey had been running for a year, and in September 2011 the Trust had received 1383 surveys from patients and their families. In August 2011, an electronic system of collecting real-time feedback commenced within specific specialist clinical areas. An increase in the number of 'free text' comments had been seen and 69% of the comments were positive. The 'Postcard to Leicester' scheme commenced across all three Outpatients Departments and a total of 2724 completed cards had been received.

A number of focus groups and adhoc surveys had been undertaken to understand any access issues for BME groups and to raise awareness with hospital staff to ask them for their feedback. Mr P Panchal, Non-Executive Director noted the progress made. The Director of Nursing advised that bespoke work in relation to obtaining feedback from young people and children was also being undertaken.

The patient experience survey returns had been analysed by age range exploring similarity between survey responses split by age and the age ranges of inpatients seen at UHL for the period April to August 2011. The data suggested that an equitable level of access to the surveys on the basis of age was being achieved. From the analysis of the patient's route of admission, it could be drawn that patients categorised as 'emergency or urgent' would require more input/a better experience in order to reach levels of satisfaction comparable to patients who have been on waiting list or were having a planned procedure. The Caring @ its Best ward level dashboards had been launched and would provide Ward Sisters with a large number of quality/outcome measures all in one document.

The Director of Communications and External Relations drew a comparison between the patient experience data in the Q&P report (paper I refers) and quarter 2 patient experience report (paper M refers) and noted that the Trust was getting better at collecting data, he noted the need for appropriate review in order to know whether it was having an appropriate effect. The Committee Chairman queried whether external support would be available to

review/translate patient experience statistics collected by the Trust - the Director of Corporate and Legal Affairs agreed to consider options to take this forward. **DCLA/ DoN**

In discussion on the patient survey results, the Director of Nursing advised that if the issues in relation to the underperforming wards in the Medicine CBU were resolved then a definite improvement could be seen. The Committee Chairman requested the Director of Nursing to provide a graph with the breakdown of comments received excluding those of the Medicine CBU from the patient experience survey for quarter two of 2011-12. The Director of Nursing also agreed to liaise with the Associate Medical Director in respect of the issues relating to the medical components of the Medicine CBU, outwith the meeting. **DoN** **DoN/ AMD**

Responding to a query in relation to the progress with 'Message to Matron' initiative, it was noted that the nurses in the Children's CBU handed out the cards personally to the families requesting feedback. Work was in progress to ensure actions were taken as a result of suggestions made.

Resolved – (A) the 2011-12 quarter 2 patient experience report be noted;

(B) the Director of Nursing be requested to provide a graph with the breakdown of comments received excluding for those of the Medicine CBU from the patient experience survey for quarter two of 2011-12 at the GRMC meeting in November 2011; **DoN/ TA**

(C) the Director of Nursing be requested to liaise with the Associate Medical Director in respect of the issues relating to the medical components of the Medicine CBU, outwith the meeting, and **DoN/ AMD**

(C) the Director of Corporate and Legal Affairs (in conjunction with the Director of Nursing) be requested to give consideration for external support to review/translate the patient experience statistics collected by the Trust. **DCLA/ DoN**

99/11 ITEMS FOR INFORMATION

99/11/1 Infection Prevention Annual Report 2010-11

Resolved – that the Infection Prevention Annual Report 2010-11 (paper N refers) be received and noted.

99/11/2 Quarterly Report from the Clinical Effectiveness Committee

Resolved – that the quarterly (quarters 1 and 2 of 2011-12) report from the Clinical Effectiveness Committee (paper O refers) be received and noted.

100/11 MINUTES FOR INFORMATION

100/11/1 Finance and Performance Committee

Resolved – that the Minutes of the 28 September 2011 Finance and Performance Committee meeting (paper P refers) be received for information.

101/11 ANY OTHER BUSINESS

101/11/1 Report from Patients Association

Resolved – that the Director of Communications and External Relations be requested to circulate the report from the Patients Association on case studies where care had fallen below standards, to the members of the GRMC for information. **DCER**

101/11/2 Electronic Prescribing

The Associate Medical Director advised that UHL would be piloting a new electronic prescribing system which was currently not used by any other hospitals in the UK. She agreed to present a report at the GRMC meeting in November 2011. **AMD**

Resolved – that the Associate Medical Director be requested to present a report on electronic prescribing at the GRMC meeting in November 2011. **AMD/ TA**

102/11 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 3 November 2011 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

(1) the issues discussed in confidential Minute 96/11/1 above.
(2) the detailed review of falls (Minute 96/11/5 above refers);
(3) dashboard of underperforming wards (Minute 97/11/1 above refers), and
(4) the progress in relation to medical metrics (Minute 97/11/3).

103/11 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 24 November 2011 from 1:15pm in Conference Rooms 1A&1B, Gwendolen House, LGH site.

POST MEETING NOTE: The date of the next meeting was subsequently changed to Friday 25 November 2011 from 9am in Conference Rooms 1A&1B, Gwendolen House, LGH site to accommodate an extended meeting of the Finance and Performance Committee on 24 November 2011.

The meeting closed at 4.13pm

Hina Majeed
Trust Administrator