Trust Board paper K

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 1 September 2011

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 28 July 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 4 August 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:

- **discussion and assurance on complaints management (Minute 62/11/2 refers) ;**
- **discussion on the review of the prevention, management and reporting of Hospital Acquired Pressure Ulcers (Minute 63/11/2 refers), and**
- **discussion on the Deloitte's Quality Governance review and associated action plan (Minute 63/11/5 refers).**

DATE OF NEXT COMMITTEE MEETING: 25 August 2011

Mr D Tracy – Non-Executive Director and GRMC Chair
25 August 2011

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 28 JULY 2011 AT 1:00PM IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Mr M Caple – Patient Adviser (non voting member)
Mr M Lowe-Lauri – Chief Executive
Mr P Panchal – Non-Executive Director
Ms C Trevithick – Deputy Director of Quality, NHS Leicestershire County and Rutland (LCR) (on behalf of Mrs E Rowbotham, Director of Quality, NHS LCR (non voting member))
Ms J Wilson – Non-Executive Director

In Attendance:
Ms S Adams – Quality and Safety Manager, Acute Care (for Minute 62/11/2)
Dr B Collett – Associate Medical Director, Clinical Effectiveness (on behalf of Dr K Harris, Medical Director)
Miss M Durbridge – Director of Safety and Risk
Dr S Jackson – Clinical Lead for Quality and Safety, Acute Care (for Minute 62/11/1)
Mrs H Majeed – Trust Administrator
Ms H Mather – Divisional Manager, Acute Care (for Minute 62/11/2)
Dr N Moore – Medical Lead, Cardio/Renal/Critical Care CBU (for Minute 62/11/2)
Ms A Randle – Senior Safety Manager (for Minute 62/11/2)
Mrs C Ribbins – Director of Nursing/Deputy DIPAC (also representing the Chief Operating Officer/Chief Nurse)

RESOLVED ITEMS **ACTION**

59/11 APOLOGIES

Apologies for absence were received from Dr K Harris, Medical Director; Mrs S Hinchliffe, Chief Operating Officer/Chief Nurse; Mrs S Hotson, Director of Clinical Quality; Mrs E Rowbotham, Director of Quality, NHS LCR; Mr S Ward, Director of Corporate and Legal Affairs; Mr M Wightman, Director of Communications and External Relations and Professor D Wynford-Thomas, Non-Executive Director.

60/11 MINUTES

Resolved – that the Minutes of and action sheet from the meeting held on 30 June 2011 be confirmed as a correct record.

61/11 MATTERS ARISING REPORT

The Committee Chair confirmed that the matters arising report (paper B) both highlighted the matters arising from the meeting held on 30 June 2011 and provided an update on any outstanding matters arising from the GRMC meetings held since October 2009. Discussion took place regarding the progress of the following items:-

(a) in respect of Minute 52/11/3, the Director of Safety and Risk agreed to discuss the current status of CIP plans with the Director of Finance and Procurement and circulate CIP schemes (one per Division) where the agreed template had been fully completed and approved to the members of the GRMC, for assurance purposes, and **DSR**

(b) the need for radios for Fire Marshals in order to aid communication (in

respect of the discussion relating to the review of organisational learning from the fire on 5 May 2011 – LRI site) (Minute 52/11/5 refers) - the Director of Nursing confirmed that this was being progressed and discussion was on-going with the police services in respect of the frequency of the radios that they used.

Resolved – that the matters arising report (paper B) be received and noted and the actions described above be taken forward accordingly. **DSR**

62/11 SAFETY AND RISK

62/11/1 Clinical Handover Process

Further to Minute 41/11/6 of 26 May 2011, Dr B Collett, Associate Medical Director and Dr S Jackson, Clinical Lead for Quality and Safety, Acute Care presented paper C, an update on the clinical handover work currently being undertaken within the Trust. They advised that standardisation of handover was vital for improvement in efficiency, patient safety and patient experience. Currently within all specialties, 3 handovers per 24 hours had been taking place, however, actual adherence to the standard had been variable. Discussions had been on-going with IM&T to develop an in-house electronic handover system. There would be two systems (doctor to doctor handover and nurse to nurse handover) in place. The development of the electronic nursing handover system was being led by Ms J Ball, Divisional Head of Nursing, Planned Care. In response to a query on the reason for two systems, it was noted that though the principles of both these systems were the same, the information recorded was to some extent different.

The Clinical Lead for Quality and Safety, Acute Care advised that the solution offered by IM&T would be piloted in the Medicine and Surgery CBUs and was due to commence on 3 August 2011. This system would allow users to record patient information and also linked with the Trust's HISS system. It would alert medical staff to patients who were acutely unwell, patients requiring action and patients with high early warning scores.

In discussion, the Associate Medical Director advised that an action plan to deliver a standardised handover process across the Trust would be presented to the GRMC in September 2011. **AMD/ DSR**

Responding to a query from the Patient Adviser, members were advised that some Trusts used off-the-shelf handover systems whereas others had created their own systems. The Clinical Lead for Quality and Safety had looked into a number of these systems and advised that the solution offered by the Trust's IM&T department was considered fit for purpose and would be piloted prior to being used Trust-wide.

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

(B) the Associate Medical Director and the Director of Safety and Risk be requested to present the action plan to deliver a standardised handover process across the Trust to the GRMC meeting in September 2011. **AMD/ DSR/TA**

62/11/2 Complaints Management, Handling, Performance and Plans

The Director of Safety and Risk introduced discussion on this item (paper D refers) advising that NHS Complaints Regulations 2009 required Trusts to make arrangements for dealing with complaints to ensure that they were dealt with efficiently and properly investigated. She noted that the GRMC had been concerned that the complaints relating to 'communications' and 'staff attitude' had not been well-managed and the reason for this presentation was to answer any queries

specifically in this respect. The Senior Safety Manager, the Acute Care Divisional Manager and Quality and Safety Manager, and Dr N Moore, Medical Lead, Cardio/Renal/Critical Care CBU attended for this item.

A brief analysis of the concerns relating to 'staff attitude' had been undertaken and it had been noticed that this was mainly in relation to locum/bank/agency/temporary staff – the Director of Safety and Risk expressed hope that the Trust might see a reduction in complaints of this nature in line with the planned reduction in locum and bank spend. The Director of Nursing reported on the significant work already undertaken in order to reduce the number of medical locum agencies to include only PASA framework agencies.

The Senior Safety Manager advised that the Patient Information and Liaison Service (PILS) combined the traditional complaints and Patient Advice and Liaison Service (PALS) roles to manage effectively concerns received by the organisation. There had been an overall increase (8.8%) in the number of formal complaints received by the Trust in 2010-11.

Responding to a query, it was noted that complaints classed under the 'communication' theme comprised a whole range of issues but very often included 'lack of information given to patients' and 'not taking time to explain to patients'. The Director of Safety and Risk suggested that a subset of themes under the main 'communication' theme might provide an informative breakdown of the reasons for the complaints in this category. In response to a query from Ms J Wilson, Non-Executive Director, it was noted that across all Divisions, it was a standard practice that all staff linked with the complaint and/or mentioned in the complaint letter would be required to read the complaint letter.

Responding to another query, members were advised that the effectiveness of the Trust's complaints process was reviewed by the complaints team on an annual basis, however the number of completed complainant evaluation forms had been low. The complaints team endeavoured to engage with patients to ascertain how they felt their complaint had been handled.

The complaints management process had improved significantly in the last 3-4 years in the view of the Chief Executive and the Director of Safety and Risk and every effort was made to arrange meetings with the complainant to resolve issues locally (there was much more personal interaction with the complainant now than before). The Corporate Safety Team also provided training to a number of staff in relation to complaints management.

The Patient Adviser queried the level of re-opened complaints and was assured by the Senior Safety Manager that face to face meetings were being offered to resolve issues. The Committee Chairman noted the wide variations in the number of complaints received each quarter but was advised that complaints were logged according to the date of receipt rather than aligned to the period of the complaint.

In the absence of representatives from the Planned Care Division, members briefly discussed paper D1 (Complaints Management – Planned Care) and were particularly impressed with the following top 3 actions that the Division would be taking to reduce complaints:-

(a) embedding and sustaining the Caring At Its Best 10 point action plan;
(b) performance management, and
(c) undertaking bi-annual (September and March) nursing activity.

The Divisional Manager, Acute Care presented paper D2, a report on complaints activity and management in her Division. She advised that both a good and bad

complaint story was discussed at their monthly Quality and Safety Committee highlighting that learning from complaints feedback was a key part of improving and developing the service.

A specific project had commenced in collaboration with Pharmacy to improve patient information given on the Acute Medical Unit at the LRI site. Complaints relating to noise at night had been resolved by the purchase and issue of earplugs for patients to use at night. The Medical Lead, Cardio/Renal/Critical Care CBU particularly noted the learning from the TAVI case (previously considered by the Committee (Minute 16/11/2 of 24 February 2011 refers)) which had resulted in changes in practice to the process for obtaining consent and revision of the patient information literature for this procedure.

Ms J Wilson, Non-Executive Director acknowledged the good work but queried whether actions were in place to pre-empt the possible causes of complaints – in response, it was noted that hourly ward rounds, improving discharge communication and customer care training for administration and clerical staff would aid in reducing the complaints received by the Division. The Divisional Manager, Acute Care noted that the Division would aim to improve discharge documentation, outlining that discharge planning should start from the time of admission.

In response to a query from the Patient Adviser, it was noted that independent scrutiny of investigations and complaint responses happened on an adhoc basis. However, Divisions were required to complete a checklist prior to signing off a complaint response. The Corporate Complaints Team undertook a monthly random check of how the complaint had been managed.

In discussion, the Committee Chairman suggested that each Division (on a rotational basis) presented a report on complaints management, handling, performance and plans to the GRMC every 4 months. **DSR**

<u>Resolved</u> – that (A) the contents of papers D, D1 and D2 be received and noted, and

(B) the Director of Safety and Risk be requested to ensure that each remaining Division (on a rotational basis) present a report on complaints management, handling, performance and plans to the GRMC every 4 months starting from November 2011. **DSR/TA**

62/11/3 <u>Report by the Associate Medical Director</u>

<u>Resolved</u> – 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.

62/11/4 <u>Report by the Director of Nursing</u>

<u>Resolved</u> – 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.

62/11/5 <u>Patient Safety Report</u>

The Director of Safety and Risk presented paper F, a summary of patient safety activity which covered the following:-

- Incident, Complaint and Inquest Cluster Review;
- Central Alerting System (CAS) exception report (no missed deadlines);

- SUIs reported in June 2011 at UHL, and
- UHL's 60 day performance regarding completed Root Cause Analysis(RCA) reports (no red ratings).

A recent review of the incidents, inquests and complaints had indicated that there had been clusters of incidents relating to ED, diagnosis and discharge. The issues relating to the cause of these incidents was integral to the ongoing work on the five critical patient safety actions, an action plan on which would be developed in conjunction with the Associate Medical Director and presented to the GRMC in August 2011. In response to a query from the Deputy Director of Quality, NHS LCR, the Director of Safety and Risk agreed to present a brief report on progress relating to the five critical safety actions to the GRMC (one per month) starting from September 2011. **DSR/ AMD** **DSR**

A total of 28 SUIs had been escalated during the month of June 2011 (6 related to patient safety incidents, 21 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3 and 4) and 1 related to healthcare associated infections).

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

(B) the Director of Safety and Risk/ Associate Medical Director be requested to present an action plan on the five critical safety actions at the GRMC meeting on 25 August 2011, and **DSR/ AMD/TA**

(C) the Director of Safety and Risk be requested to present a brief report on progress relating to the five critical safety actions to the GRMC (one per month) starting from September 2011. **DSR/TA**

63/11 QUALITY

63/11/1 Nursing Metrics and Extended Nursing Metrics

The Director of Nursing presented paper G, a summary of nursing metrics performance for June 2011, particularly noting progress made on eight indicators since May 2011. Out of the13 metrics in place, 11 scored 'green' and 2 'amber'. Project VITAL had been launched and 400 nursing staff had completed the modules.

Paper G1 detailed the implementation of a range of nursing care metrics in the specialist areas within UHL. Responding to a query, it was noted that all ward areas had delivered sustained improvement and no wards were subject to a 'health-check'. The Director of Nursing advised that if any indicators remained 'green' for a considerable period of time then consideration would be given to inclusion of new indicators. In response to a query from the Director of Safety and Risk regarding the ratio between patient complaints and nursing metrics, the Director of Nursing suggested that the metrics provided a snap-shot of performance rather than a definitive indicator.

Mr P Panchal, Non-Executive Director queried progress on the hourly ward rounds – in response, the Director of Nursing advised that hourly ward rounds had been rolled out in 85% of wards in UHL.

Resolved – that the contents of the nursing metrics and extended nursing metrics reports (papers G & G1 refer) be received and noted.

63/11/2 Review of the Prevention, Management and Reporting of Hospital Acquired Pressure Ulcers (HAPUs)

The Director of Nursing advised that there had been a gradual reduction in the

number of HAPUs reported for February, April and May 2011, however, this had been followed by a sharp increase in the number of incidents reported in June 2011, prompting an immediate Trust-wide review. Paper H outlined the prevention, management and reporting of HAPUs in UHL and noted that Commissioners had recognised UHL's excellent reporting culture for incidents.

The review confirmed that many nursing practices around the prevention and management of pressure ulcers had improved including nursing documentation, but the grading of pressure ulcers and appropriate use of pressure relieving aids were areas requiring further action. A Matron from the Medicine CBU was now responsible for supporting the speedy implementation of actions. Further education through the VITAL module in respect of early recognition of pressure ulcers would be provided in ward areas.

Further collaborative working with Commissioners was proposed in order to provide an opportunity to standardise the classification and reporting of statistics, particularly in relation to pressure ulcers that developed shortly after admission and other forms of skin damage such as moisture lesions and ischaemic ulcers. The Tissue Viability Team in conjunction with Vascular Surgeons planned to review the increased incidence of heel ulcers.

Ms J Wilson, Non-Executive Director queried the reasons for the increase in HAPUs in June 2011 – in response, the Director of Nursing indicated that educational interventions for nurses around the aetiology and prevention of ulcers and the importance of assessing all pressure ulcers on admission in particular for patients who had been admitted to hospital following falls at home might be one of the reasons but she agreed to review this in further detail. The wards that had reported the highest number of HAPUs were now being closely monitored and supported by the Divisional Heads of Nursing to ensure that the CQUIN threshold (20% reduction in the number of pressure ulcers) was achieved by 31 March 2012. **DoN**

The Committee Chairman expressed concern that there was conflicting information (nursing metrics for June 2011 reported that pressure area care was 97%, rated 'green'). He requested that benchmarking information on acute pressure ulcers (specifically comparing like with like) be provided to the GRMC. However, he noted that the HAPUs for July 2011 had reduced. The Director of Nursing commented that qualitative work had been undertaken which showed a higher acuity of patients in the Medicine CBU. She agreed to provide a progress report on the ongoing actions in reducing avoidable HAPUS to the GRMC in September/October 2011. **DoN** **DoN**

<u>Resolved</u> – that (A) the contents of paper H be received and noted, and

(B) the Director of Nursing be requested to:- **DoN/TA**

- **(i) provide benchmarking information on acute pressure ulcers (specifically comparing like with like);**
- **(ii) indicate the reasons for the increase in HAPUs in June 2011, and**
- **(iii) provide a progress report on the ongoing actions in reducing avoidable HAPUs in addition to an update on points (i) and (ii) above at the GRMC in September/October 2011.**

63/11/3 <u>Quality and Performance Report – Month 3</u>

The Director of Nursing presented papers I and I1, the quality, finance and performance report and heat map for month 3 (month ending 30 June 2011). The following points were highlighted in particular:-

- sustained improvement in performance evidenced in relation to ED;

- no MRSA cases had been reported for a second successive month with a year to date figure of 2 (year end target of 9);
- slight deterioration in RTT performance for admitted patients, and
- full compliance with Same Sex Accommodation guidance.

Responding to a query, the Chief Executive advised that work was underway with colleagues in EMAS to aid patient flows in order to further sustain the improved performance in ED.

Resolved – that the quality and performance report and divisional heat map for month 3 (month ending 30 June 2011) (papers I and I1) be received and noted.

63/11/4 Theatre Modernisation Programme

In discussion on paper J, an update on the theatre modernisation programme, members raised the following queries:-

(i) whether plans were in place to focus on patient experience aspects when the planned theatre closures would take place;
(ii) whether plans were in place to deal with variations at peak times (i.e. bank holidays), and
(iii) the requirement for much fuller information under section 2.5 of the paper (specifically outlining whether the TPOT was being delivered as anticipated).

The Committee Chairman agreed to raise the above queries with the Divisional Manager, Clinical Support. **GRMC Chair**

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

(B) the Committee Chairman be requested to ensure that the queries in points (i) to (iii) above were raised with the Divisional Manager, Clinical Support. **GRMC Chair**

63/11/5 Deloitte's Quality Governance Review and Associated Action Plan – Update

Further to Minute 28/11/8 of 28 April 2011, the Associate Medical Director (in the absence of the Director of Clinical Quality), presented paper K, an update on progress against the Deloitte's Quality Governance review and action plan. She advised that the July 2011 update was shown in 'bold' font in appendix 1 of paper K. Progress had been made against all the recommended actions, with no 'red' ratings. A number of actions had been rated 'amber' as they required regular review as part of routine governance processes. Members noted that the Executive Team would be undertaking further work to monitor and continually improve the quality of healthcare for UHL's patients.

In response to a query, the Associate Medical Director agreed to check the reason for 'N/A' being specified in the 'date for completion' column for some of the recommended actions in the Deloitte's action plan. Members also noted the need to review the content of sub-committee meetings to ensure that key working groups were effective at resolving issues. The Committee Chairman suggested that a further update on progress against the Deloitte's action plan be presented to the GRMC in October 2011. **AMD** **DCLA** **DCQ**

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

(B) Director of Clinical Quality be requested to check the reason for 'N/A' being specified in the 'date for completion' column for some of the recommendations in the Deloitte's action plan; **DCQ**

(C) the Director of Clinical Quality be requested to present a further update on progress against the Deloitte's action plan at the GRMC meeting in October 2011, and **DCQ/TA**

(D) the Director of Corporate and Legal Affairs be requested to review the content of sub-committee meetings to ensure that key working groups were effective at resolving issues. **DCLA**

63/11/6 VTE Assessment – CQUIN Target

Further to Minute 28/11/9 of 28 April 2011, the Associate Medical Director presented paper L, a report on UHL's current performance in respect of compliance with VTE assessment. There had been an improvement in the percentage (currently 86%) of patients risk assessed for VTE within 24 hours of admission, however, performance remained below the expected 90% threshold. The implementation of the VTE risk assessment for elective cases had been satisfactory but there was a need to improve performance particularly in emergency admissions.

The requirement was to risk assess patients for VTE within 24 hours of admission and ensure that the results were entered onto iCM. VTE assessments were currently championed by Haematology CBU and Trust-wide champions were being considered. Mrs C Mason, HM Coroner had offered to meet with junior doctors to raise awareness of the importance of VTE assessments. Divisions were provided with monthly reports showing which patients were missing details of their VTE risk assessment on Patient Centre. Divisions had been tasked to review procedures and raise awareness further particularly in respect of consistency in data capture of the VTE risk assessments and recording on Patient Centre.

Responding to a query, it was noted that monitoring compliance with VTE risk assessment would now be included as part of medical metrics and would not feature on the nursing metrics. The Associate Medical Director advised that incorporation of a VTE risk assessment tool into the e-prescribing system was being considered – this would be a more robust way of ensuring risk assessments routinely took place electronically as use of this tool would be a mandatory requirement in order to prescribe patients' medications.

In response to a query from the Committee Chairman in respect of when the 90% target would be met, the Associate Medical Director advised that the Trust was currently working towards compliance with the target, however, she re-iterated that should the Trust not meet the target then financial penalties would be implemented from September 2011. The Committee Chairman requested an update on progress at the GRMC meeting in August 2011. **AMD**

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

(B) the Associate Medical Director to provide an update on progress in achieving the national VTE risk assessment CQUIN to the GRMC in August 2011. **AMD/TA**

64/11 PATIENT EXPERIENCE

Quarter 1 (2011-12) Patient Experience Report

The Director of Nursing presented paper M, an update on the patient and family experience feedback plan and the 'Caring at its Best 10 point plan' for quarter 1 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 June 2011 the Trust had received 1449 surveys from patients and their families. An electronic system of collecting feedback would be rolled out to some areas from July 2011. Regular feedback from patients and families via the NHS Choices website had also been collected. Appendix one outlined the outpatient survey results over April and May 2011.

The patient experience feedback activity highlighted that there had been a low response rate from ethnic minority groups. The patient experience team planned to schedule regular events to actively engage with specific ethnic minority groups seeking feedback specifically to the present survey and also for more general qualitative feedback. In discussion on this matter, the Director of Nursing agreed to undertake further work with Mr P Panchal, Non-Executive Director to ensure that actions were in place to ascertain the views of carers from Black Minority and Ethnic backgrounds in respect of patient experience surveys. **DoN**

The Caring at its Best 10 point plan provided an update on the initiatives within the Trust to improve care for patients in response to the feedback from the surveys.

Responding to a query from the Patient Adviser, the Associate Medical Director advised that a 'discharge by lunch time' project had commenced which would consider different aspects of discharge planning, thereby reducing the low satisfaction rate in respect of discharge.

In response to a query from Mr P Panchal, Non-Executive Director, the Director of Nursing advised that five dignity retreat rooms were now available across the Trust with a further 17 rooms identified for improvement in the future. Mr P Panchal, Non-Executive Director had a further query relating to procedures in place in some areas within Maternity Services – on which he agreed to liaise with the Director of Nursing outside the meeting. **PP, NED**

The Director of Safety and Risk queried the launch date of the 'Message to Matron' postcard initiative – in response, it was noted that this initiative had already been launched in some clinical areas and a full Trust wide roll-out would commence during the first week of September 2011.

<u>Resolved</u> – (A) the contents of paper M be received and noted;

(B) the Director of Nursing be requested to undertake further work with Mr P Panchal, Non-Executive Director to ensure that actions were in place to ascertain the views of carers from Black Minority and Ethnic backgrounds (given the low response rate from this group) in respect of patient experience surveys, and **DoN**

(C) Mr P Panchal, Non-Executive Director be requested to liaise with the Director of Nursing, outside the meeting regarding a query relating to procedures in place in some areas within Maternity Services. **PP,NED**

65/11 ITEMS FOR INFORMATION

65/11/1 <u>Professor Munroe's Review of Child Protection Services – Government Response</u>

<u>Resolved</u> – that the report on Government's response to Professor Munroe's Review of Child Protection Services (paper N refers) be received and noted.

66/11 MINUTES FOR INFORMATION

66/11/1 Finance and Performance Committee

Resolved – that the public minutes of the Finance and Performance Committee meeting held on 29 June 2011 (paper O refers) be received and noted.

67/11 ANY OTHER BUSINESS

There were no items of any other business.

68/11 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 Trust Board:

- **discussion and assurance on complaints management (Minute 62/11/2 above refers) ;**
- **discussion on the review of the prevention, management and reporting of Hospital Acquired Pressure Ulcers (Minute 63/11/2 above refers), and**
- **discussion on the Deloitte's Quality Governance review and associated action plan (Minute 63/11/5 above refers).**

69/11 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 25 August 2011 from 9:30am in Conference Rooms 1A&1B, Gwendolen House, LGH site.

The meeting closed at 3:55pm.

Hina Majeed
Trust Administrator