Paper O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 2 June 2011

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 28 April 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 5 May 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:

There are no specific issues to be highlighted to the Trust Board from the Governance and Risk Management Committee.

DATE OF NEXT COMMITTEE MEETING: 26 May 2011

Mr D Tracy – Non-Executive Director and GRMC Chair
26 May 2011

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 28 APRIL 2011 AT 9:30 AM IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Mr M Lowe-Lauri – Chief Executive
Mr P Panchal – Non-Executive Director
Mrs E Rowbotham – Director of Quality, NHS Leicestershire County and Rutland (NHS LCR)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations

In Attendance:
Mr M Caple – Patient Adviser
Miss M Durbridge – Director of Safety and Risk
Mrs H Majeed – Trust Administrator
Mr J Roberts – Assistant Director of Information (for Minute 27/11/2)
Professor D Rowbotham – Chair of the Fractured Neck of Femur (#NOF) Steering Group (for Minute 27/11/1)

RESOLVED ITEMS **ACTION**

24/11 APOLOGIES

Apologies for absence were received from Mrs S Hotson, Director of Clinical Quality; Mrs C Ribbins, Director of Nursing/Deputy DIPAC; Ms J Wilson, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director.

25/11 MINUTES

Resolved – that (A) the public and private Minutes (papers A and A1 refer) of the meeting held on 24 February 2011 be confirmed as a correct record, and

(B) the contents of the associated Governance and Risk Management Committee action sheet arising from the same meeting (paper A2 refers) be received and noted.

26/11 MATTERS ARISING REPORT

The Committee Chair confirmed that the Matters Arising report (paper A3) highlighted the matters arising from the meeting held on 24 February 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 item:-

(a) proposed system of reporting 10 x medication errors - it was noted that this issue had been discussed at the QPMG meeting on 6 April 2011. Continued reporting of all 10 x medication errors was expected, but work would be undertaken in terms of how these were subsequently graded, with all such medication errors reviewed internally, but only those 10 x medication errors actually administered to the patient being reviewed by the Medicines Management Committee. By using this methodology, the Trust would now be in line with the reporting system used by peer Trusts. If the members of the GRMC had any specific concerns, then a report from the Medicines Management Committee could be requested.

<u>Resolved</u> – that the matters arising report (paper A3) and subsequent discussion on progress of a specific item be received and noted.

27/11 MATTERS ARISING

27/11/1 <u>Progress Report on Fractured Neck of Femur (#NOF) (Minute 03/11/2 of 27 January 2011)</u>

Professor D Rowbotham, Chair of the #NOF Steering Group attended the meeting to present paper B, an update on the actions being taken to achieve the revised #NOF target of 36 hours to theatre from being diagnosed or admitted. He apologised for the lack of robustness of the paper. The Chair of the #NOF Steering Group advised that despite a number of measures having been put in place by the team, recent performance showed that only 75% of patients who sustained a hip fracture were having their operation within 36 hours of becoming clinically fit for surgery (noting that the PCT's target was 90%). However, UHL's average time to theatre was 31 hours compared to other Trusts nationally which was 38 hours. The average length of stay for this group of patients was 16 days compared to 19 days nationally. UHL's #NOF mortality rate was slightly above national average. However, UHL's mortality rate in respect of this indicator had remained the same in 2009-10 and 2010-11, in spite of a number of a number of improvements being put in place since April 2010.

The Chair of the #NOF Group emphasised that the Steering Group worked exceptionally well noting that the team felt that an additional theatre might prove useful. In response to a query, it was noted that Leeds Teaching Hospital NHS Trust had significantly achieved the PCT's target and it was highlighted that elective and emergency admissions were based on one site at this Trust. However, it was noted that Trusts which had assigned a dedicated #NOF ward had fared well in achieving this target. The Committee Chair queried whether an additional theatre and ward was an economically viable option - in response, it was noted that this was a matter of reorganising existing ward arrangements. The Chief Operating Officer/Chief Nurse was supportive of having a dedicated #NOF ward advising that the nurse to bed ratios would need to be altered in addition to the requirement of correct skill mix and clinician complement. The Chief Executive suggested that a local study by one of the junior doctors be undertaken to find out whether a dedicated #NOF ward would contribute to any further improvement in achieving this target (taking into account the quality of acute nursing, post-operative care etc.). **C#NO FSG**

Responding to a query from the Chief Executive, it was noted that two Consultant Ortho-Geriatricians had now been appointed and thereby the issue in relation to orthogeriatric cover had therefore been resolved.

The Chief Executive suggested that consideration be given to UHL representatives visiting Mr M Parker, Consultant Orthopaedic Surgeon, Peterborough Hospitals FT to discuss his work in relation to femoral neck fractures – the Chair of the #NOF Steering Group agreed to discuss with his team and take this forward. **C#NO FSG**

The Committee Chair requested that a further progress report be presented to the GRMC meeting in June 2011. **C#NO FSG**

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

(B) the Chair of the #NOFSG be requested to ensure that:-

- **a study be undertaken to ascertain whether a dedicated #NOF ward would contribute to any further improvement in achieving the PCT's target;** **C#NO FSG**
- **consideration be given to visiting Mr M Parker, Consultant Orthopaedic Surgeon, Peterborough Hospitals FT to discuss his work in relation to**

femoral neck fractures, and

(C) the Chair of the #NOFSG be requested to present a progress report on the achievement of the revised #NOF target at the Governance and Risk Management Committee in June 2011. **C#NOFSG/TA**

27/11/2 Update on Clinically Led Coding (Minute 14/11/1)

Mr J Roberts, Assistant Director of Information attended the meeting and provided a verbal update on the progress in relation to the clinically led coding project. Ms T Pender, Senior Project Manager had been appointed to take forward this programme. Discussions were continuing with Clinicians in addition to new and revised data collection processes being introduced in some specialties.

The 'Encoder' was a new electronic system which was a clinical coding translator and a 12-week programme of this system was being piloted within the Trust. It was expected to go-live in mid-July 2011.

An initial draft of the clinical coding dashboard had been developed and would be initially presented to the Clinical Effectiveness Committee (CEC) for comments. The PERL performance tool would enable the Trust to benchmark itself with peer Trusts. The results of an external audit of the clinical coding team would also be reported to the CEC.

An internal audit of 200 episodes in elective orthopaedics had indicated errors in coding which resulted in a small financial loss to the Trust. The Director of Communications and External Relations suggested that Commissioners and GP colleagues should be involved in the development of the Trust's clinical coding programme – in response, the Assistant Director of Information agreed to take this forward. **ADI**

The risks and next steps of this programme were highlighted. The Medical Director commented that most Clinicians would be happy to be involved in the clinically led coding process. The Committee Chair requested that an update on the Encoder system and benchmarking information be provided to the GRMC in July 2011. **ADI**

Resolved – that (A) the verbal update be received and noted;

(B) the Assistant Director of Information be requested to ensure Commissioner and GP engagement in the Trust's clinical coding programme, and **ADI**

(C) the Assistant Director of Information be requested to provide an update on the implementation of the Encoder system and benchmarking information at the GRMC meeting in July 2011. **ADI/TA**

28/11 QUALITY

28/11/1 Roll-out of Nursing Metrics

(a) The Chief Operating Officer/Chief Nurse presented paper C, a summary of nursing metrics performance for February and March 2011, particularly noting significant improvements in continence care (post five months of monitoring) which had reached 90% compliance. A total of 13 metrics were in place and 9 scored 'green', 1 'amber' and 3 'red'. Slight amendments were to be made in adding a further infection prevention standard to the medicine prescribing metric.

The Chief Operating Officer/Chief Nurse advised that she had met with the ward sisters to consider metrics performance. Meetings had been arranged with the staff

nurses across the Trust to further discuss the nursing metrics performance indicators.

Responding to a query from the Committee Chair, it was noted that the swing wards were monitored as part of the nursing metrics but the results were not reported as these wards were opened only on a temporary basis. It was noted that the swing wards had always been rated either 'green' or 'amber' but never 'red'. In response to a query from the Patient Adviser, the Chief Operating Officer/Chief Nurse listed the criteria to meet the 'discharge' indicator noting that this metric had been amended to reflect the 2011 quality schedule.

In response to a comment from Mr P Panchal, Non-Executive Director, the Chief Operating Officer/Chief Nurse acknowledged that the two elderly care wards which now had hourly nurse rounds in place, scored particularly well.

(b) The Chief Operating Officer/Chief Nurse advised that further to the monthly monitoring of the nursing metrics, a ranking was published thereby creating healthy competition amongst ward areas. It was noted that the compliance challenge was across the whole Trust and there were no specific ward areas which were an outlier in respect of any particular indicator.

(c) The Chief Operating Officer/Chief Nurse reported verbally, providing a list of Trusts which used the nursing metrics tool. The benchmarking information was discussed twice a year with Trusts in the North West, West Midlands and South East of England. In response to a query, it was noted that UHL had started using this tool in all ward areas from May 2010 and significant improvement in outcome measures and patient experience had been noticed in 2011. Responding to a query from the Director of Quality, NHS LCR, members were advised that this tool was currently being used only by Acute Trusts.

The Director of Safety and Risk queried whether the Trusts which scored well in the nursing metrics had demonstrated a decrease in SUIs, complaints etc. – in response, the Chief Operating Officer/Chief Nurse advised that further to embedding, it might take at least two years to notice a difference, however, for bigger Trusts it might take even longer. Responding to another query, it was noted that the Releasing Time to Care wards were always in the upper quartile in respect of nursing metrics performance.

<u>Resolved</u> – that the contents of the nursing metrics report (paper C refers) be received and noted.

28/11/2 <u>Extended Nursing Metrics</u>

(a) The Chief Operating Officer/Chief Nurse presented paper D, a summary of the metrics performance for departments/specialist areas (day surgery, outpatients, theatres, antenatal and postnatal) from September 2010 to March 2011. It was noted that improvements in the specialist areas were noticeable more quickly than in general ward areas.

In response to a query, it was noted that metrics for Allied Health Professionals and Medical staff would also prove useful. The Medical Director highlighted that a range of medical metrics were available to gauge performance, some of which were reported to the CEC. Members discussed at length the creation of meaningful metrics for the medical workforce. Further to discussion, it was suggested that the Chief Operating Officer and the Medical Director take this forward and provide an update at the GRMC meeting in May 2011. The Director of Corporate and Legal Affairs suggested that the clinical audit programme could provide assurance on the control measures and be reported to the GRMC via the quarterly report from the Clinical Effectiveness Committee. **COO/ CN/MD**

Responding to a concern from the Committee Chair, the Chief Operating Officer/Chief Nurse advised that dignity retreat areas were now available for families to listen to end of life information. Members were also briefed on the same sex accommodation facilities available in UHL. Admitted patients would share the room where they slept only with members of the same-sex and same-sex toilets and bathrooms would be close to their bed area. Sharing with members of the opposite sex would only happen when clinically necessary. In some areas, confused patients might wander to areas where there were patients of the opposite sex. This situation would happen only due to the condition of the patient and a member of staff would provide an apology to the other patients in that area.

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

(B) the Chief Operating Officer/Chief Nurse and the Medical Director be requested to take forward the action in respect of creating meaningful metrics for the medical workforce and provide an update at the GRMC meeting in May 2011 regarding the best way forward. **COO/ CN/MD /TA**

28/11/3 Theatre Modernisation Programme

Paper E provided an update on the progress and delivery of the Theatre Modernisation Programme (TMP). This paper had also been presented to the Finance and Performance Committee on 27 April 2011. Improvement in overall UHL inpatient (10%) and day case (8%) theatre utilisation had been evident over the last three quarters. The theatre utilisation performance currently stood at 91% with theatres being run from 9am-5pm. However, consideration was being given to running theatres from 8am-8pm in order to increase the utilisation rate to 94%. Implementation of this would involve a culture change and staff would need to understand that this initiative would allow the Trust to make more effective use of its assets. Responding to a query, it was noted that a majority of Trusts had an extended theatre opening time. Section 6 of the paper detailed the workforce review noting that a management of change report had been presented to all theatre staff.

An independent audit of checklist use and team briefings in selected theatres across the Trust was being rolled out by one of the CBUs to ascertain the best method of implementing the safe surgery checklist. The initial issues relating to the transfer of sterile services provision to Synergy were being resolved. The Director of Safety and Risk suggested that the learning from theatre areas could also be implemented within other areas (i.e. Cath Laboratory) in order to improve quality and safety.

The Chief Operating Officer/Chief Nurse suggested that four-monthly reports on progress with the TMP be presented to the GRMC. **COO/ CN**

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

(B) the Chief Operating Officer/Chief Nurse be requested to present four-monthly reports on progress with the Theatre Modernisation Programme. **COO/ CN/TA**

28/11/4 External Accreditation

The Medical Director presented paper F, an update on forthcoming accreditation visits in addition to visits that had been recently completed.

In response to queries from the Committee Chair, it was noted that:-

(a) further to the report received from the peer review of Cancer Services, UHL had provided a response on the actions it had taken to resolve the issues and

this had been accepted by the National Cancer Peer Review Team, and

(b) in respect of NPSA's PEAT inspection, UHL had scored 'good' for cleanliness, 'excellent' for food and 'good' for environment.

Resolved – that the contents of paper F be received and noted.

28/11/5 Clinical Audit – Follow up Review

Further to Minute 116/10 of 9 November 2011, the Medical Director presented paper G, a report providing assurance of progress against the action plan arising out of East Midlands Internal Audit review of clinical audit. A follow-up review had been completed to examine the extent to which the agreed actions had been implemented. It was noted that, as with any follow-up review by Internal Audit, a revised audit opinion would not be provided, however, informal feedback by the assessors suggested that the progress made would equate to 'significant assurance'.

The Committee Chair requested that a report on clinical audits and their results (equivalent to the report used by Nottingham University Hospitals NHS Trust) be presented to the GRMC in May 2011. **DCQ**

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

(B) the Director of Clinical Quality be requested to present a report on UHL's clinical audits and their results to the GRMC in May 2011. **DCQ/ TA**

28/11/6 Maintaining and Improving Quality During the Transition: Safety, Effectiveness, Experience – Part 1 2011-12, National Quality Board, March 2011

Resolved – that further to Trust Board Minute 7/11/1 of 6 January 2011 the contents of paper H (including progress on completing the checklist) be noted.

28/11/7 Quality Governance in the NHS – A guide for Provider Boards, National Quality Board, March 2011

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

(B) the Director of Clinical Quality be requested to take forward the actions to implement the Quality Governance Framework and provide an update on progress at the GRMC meeting in July 2011. **DCQ/ TA**

28/11/8 Deloitte's Quality Governance Review and Associated Action Plan

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

(B) the Director of Clinical Quality be requested to provide an update on progress with the action plan in respect of Deloitte's Quality Governance review at the GRMC meeting in July 2011. **DCQ/ TA**

28/11/9 Venous Thrombo-Embolism (VTE) Assessments

Further to Minute 04/11/2 of 27 January 2011, the Medical Director presented paper K, a report on progress made in respect of compliance with VTE assessments, developing an electronic system to capture this data and monitoring and reducing hospital acquired thrombosis (HATs).

The Medical Director highlighted the following in particular:-

(i) there had been an improvement in the percentage (currently 80%) of

patients risk assessed for VTE within 24 hours of admission, however, performance remained below the 90% threshold;

(ii) data was being recorded on Patient Centre and work was nearly completed on the iCM electronic version of the risk assessment tool;

(iii) developments were also underway to include a risk assessment tool as part of the e-prescribing system which would provide a longer term solution, and

(iv) there had been a reduction in the number and rate of HATs.

In response to a query from the Director of Communications and External Relations, the Medical Director advised that a root cause analysis would be undertaken for every case of hospital acquired thrombosis. If the Trust was able to demonstrate that appropriate prophylaxis was given, then the HAT would fall under the 'unavoidable' category.

Responding to a query from the Chief Executive, the Chief Operating Officer/Chief Nurse advised that the SHA had been involved and they had suggested that with agreement from Commissioners, the fine might be waived in respect of currently not achieving the national CQUIN where '90% of patients have a risk assessment of VTE within 24 hours of admission', noting that UHL had a system in place but it was a technology issue. The Director of Quality, NHS LCR commented that there was an expectation that this waiver was time limited. The Medical Director re-iterated that the Trust was moving towards a positive upward trajectory but the ability to deliver a technical solution was a major challenge. It was suggested that the Medical Director and the Director of Quality, NHS LCR discuss the timescales to achieve the 90% target outside the meeting and the outcome be reported to a subsequent GRMC meeting. **MD**

The Director of Safety and Risk suggested that it would be worth liaising with Community Clinicians in order to resolve any issues relating to pre-admissions.

The Committee Chair suggested that an update on progress in achieving the national CQUIN in addition to benchmarking information relating to VTE assessments be provided to the GRMC, when available. **MD**

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

(B) the Medical Director be requested to provide an update on progress in achieving the national CQUIN in addition to benchmarking information relating to VTE assessments, when available. **MD/TA**

28/11/10 <u>Quality Account 2010-11</u>

<u>Resolved</u> – that the Director of Clinical Quality be requested to present the quality account for 2010-11 to the GRMC in May 2011 ahead of submission to the Trust Board in June 2011, for approval. **DCQ/ TA**

29/11 SAFETY

29/11/1 <u>Patient Safety Report</u>

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

- new list of DoH's 'Never Events';
- priority safety actions for 2011-12;
- 2010-11 complaints review;
- CAS exception report;
- SUIs reported in February and March 2011 at UHL, and
- UHL's 60 day performance regarding completed RCA reports.

It was noted that the 2011-12 list of never events which had come into effect from 1 April 2011, had moved from eight to twenty five never events, and the existing eight had been strengthened. The latest never event policy also contained details regarding the principles of cost recovery by Commissioners from provider Trusts, whereby, subject to various guidance, payment for care relating to a never event would be withheld.

The Director of Safety and Risk advised that the Patient Safety team had reviewed and analysed avoidable mortality and morbidity as reported through incidents, complaints, inquests and claims to determine the priority safety actions for 2011-12, noting that these were currently being widely communicated throughout the Trust and would be discussed in depth by the Quality and Performance Management Group (QPMG).

In discussion on the five critical safety actions, members queried the reason for infection prevention not being in this list of actions – in response, it was noted that infection prevention was one of the underlying common themes, however when the RCA reports of SUIs had been reviewed, the following five trends were considered as the areas where priority action was required:-

(a) improving clinical handovers;
(b) relentless attention to EWS triggers and actions;
(c) development of on-going monitoring arrangements in respect of CIP schemes;
(d) implementation and embedding mortality and morbidity standards, and
(e) improving clinical documentation and notation.

In response to a query from the Director of Corporate and Legal Affairs, it was noted that the QPMG report for its meeting on 4 May 2011 listed some suggestions on how to achieve and measure the above five priority safety actions. The Director of Quality, NHS LCR requested a copy of the QPMG paper which the Director of Safety and Risk agreed to forward. **DSR**

Section 4 of the paper listed the CAS alert (Acute Care Division) that had missed the deadline in March 2011 but this had now been closed.

A total of 83 SUIs were escalated during the months of February and March 2011 (19 related to patient safety incidents, 57 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3 and 4) and 7 related to healthcare associated infections). In discussion on incident (reference: W65692), the Chief Executive requested that the Chief Operating Officer/Chief Nurse assure herself that the issue identified with this incident was not indicative of any deeper clinical risk issue in that area. **COO/ CN**

On request, the Director of Safety and Risk provided a detailed briefing in respect of incident reference: W65737. It was noted that an external review (a Specialist Paediatric Nurse and Clinician from the North West would form part of the review team) of this incident would be undertaken and that a Commissioner representative would also be part of the review team.

In response to a comment from Mr P Panchal, Non-Executive Director, it was suggested that discussion be held with the Director of Safety and Risk outside the meeting, to resolve any further queries in relation to process of reporting and management of SUIs. **PP,NED/DSR**

Paper L1 provided an overview of the complaints activity for 2010-11. The report listed the number of complaints by type noting that there had been a 5% increase in 2010-11 compared to 2009-10. The Committee Chairman queried whether 'requests for information' should be treated as a complaint.

The Director of Communications and External Relations suggested that the emergent complaint themes in addition to the age and ethnicity of the complainant would prove useful. Further to identification of the themes, an action plan for addressing the issues would be helpful for the CBUs/Divisions. The Patient Adviser expressed concern that 215 complaints out of 1535 formal complaints in 2010-11 had been re-opened – in response, the Director of Safety and Risk advised that work was on-going with CBUs to improve the effectiveness of the complaint response letter. The Chief Executive suggested that the reasons for the increased number of re-opened complaints and the actions required to be put in place to address these issues should be discussed by the QPMG and reported to the GRMC. **COO/CN/DSR**

Responding to a query from the Patient Adviser, it was noted that complaints were discussed by Divisions either at their Board meetings or Quality Governance meetings, as appropriate.

In summary, the Committee Chair requested the following information to be provided to the GRMC:- **DSR**

(a) the reasons/issues for the increase in complaints, and
(b) the actions that had been put in place to address this.

Members highlighted that compliments received should also be appropriately recorded. In discussion on long-standing complaints, the Committee Chair suggested that consideration might be given to invoking the 'vexatious' element of UHL's complaints process, where appropriate.

<u>Resolved</u> – that (A) the contents of papers L&L1 be received and noted;

(B) the Director of Safety and Risk be requested to provide reasons/issues for the increase in complaints and the actions put in place to address this; **DSR/TA**

(C) the Chief Operating Officer/Chief Nurse and the Director of Safety and Risk be requested to discuss at a QPMG meeting, the reasons for the increased number of re-opened complaints and the actions put in place to address these issues and a report be presented to the GRMC, as appropriate; **COO/CN/DSR/TA**

(D) the Director of Safety and Risk be requested to forward the detailed patient safety report for the QPMG on 4 May 2011 to the Director of Quality, NHS LCR, and **DSR**

(E) Mr P Panchal, Non-Executive Director be requested to discuss with the Director of Safety and Risk outside the meeting his queries in relation to the process of reporting and management of SUIs. **PP, NED/DSR**

29/11/2 <u>CIPs</u>

The Chief Operating Officer/Chief Nurse presented paper M, a report on an overview of the 2011-12 cost improvement status and assurance plans. A robust evaluation

process would be used to assess the clinical quality, patient safety and business risks for every project undertaken. Appendix 1 of the paper provided a risk assessment form which project managers would be required to complete and score the project risk. The Director of Safety and Risk and her team would be liaising with Divisions to ascertain whether they were clear with the guidance.

The Director of Quality, NHS LCR queried whether the Trust's Cost Improvement Programme would be reviewed by a third party – in response, the Chief Operating Officer/Chief Nurse advised that this had currently not been arranged but consideration would be given for External Audit review of the higher value schemes, if required and as appropriate.

Resolved – that the contents of paper M be received and noted.

29/11/3 OFSTED Children's Services Review

Resolved – that the contents of paper N be received and noted.

29/11/4 Annual Safeguarding Report – Children and Adults

Resolved – that the contents of paper O be received and noted.

29/11/5 Safeguarding Case Reviews (SCRs)

The Chief Operating Officer/Chief Nurse reported verbally on one high profile case which involved a number of organisations and related to a case in 2007. Members also noted brief details of another SCR.

Resolved – that the verbal update be received and noted.

29/11/6 Report by the Chief Operating Officer/Chief Nurse

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.

30/11 PATIENT EXPERIENCE

30/11/1 Quality and Performance Report – Month 12

The Chief Operating Officer/Chief Nurse presented papers Q and Q1, the quality, finance and performance report and heat map for month 12 (month ending 31 March 2011). The 2011-12 NHS performance framework indicators were appended to this report for the Trust Board meeting in May 2011. Discussions were on-going and the Trust was in discussion with NHS East Midlands regarding the reasonableness of the proposed CDiff trajectory of 165 cases for 2011-12.

Resolved – that the quality and performance report and divisional heat map for month 12 (month ending 31 March 2011) (papers Q and Q1) be received and noted.

30/11/2 Quarterly Patient and Family Experience Report

Resolved – that this item be deferred to the GRMC meeting in May 2011. **DoN/ TA**

31/11 ITEMS FOR INFORMATION

31/11/1 Update on Outstanding Tissue Viability SUIs

Resolved – that the update on outstanding tissue viability SUIs (paper S refers) be received and noted.

31/11/2 CQC's Review of Compliance – Glenfield Hospital

Resolved – that the report on CQC's review of compliance against the essential standards of quality and safety at the Glenfield Hospital site (paper T refers) be received and noted.

31/11/3 Inquest Outcome – CB

Resolved – that the Trust's response to the Coroner's letter in relation to the above case (paper U refers) be received and noted.

31/11/4 Finance and Performance Committee Minutes

Resolved – that the public and private minutes of the Finance and Performance Committee meeting held on 24 February 2011 (paper V) be received and noted.

31/11/5 Care and Compassion – Older People's Care within UHL

Resolved – that this report (paper D refers) be accessed through www.uhl-tr.nhs.uk/aboutus/our-trust-board/meeting-papers/7-april-2011

31/11/6 2011-12 CQUIN Report

Resolved – that this report (paper I refers) be accessed through www.uhl-tr.nhs.uk/aboutus/our-trust-board/meeting-papers/7-april-2011

31/11/7 Cancer 2-Week Wait Appointments

Resolved – that this report (paper P (paper 1) refers) be accessed through www.uhl-tr.nhs.uk/aboutus/our-trust-board/meeting-papers/7-april-2011

32/11 ANY OTHER BUSINESS

There were no items of any other business.

33/11 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that there were no issues to be highlighted to the Trust Board.

34/11 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 26 May 2011 from 9:30am-12:30pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 12:50pm.

Hina Majeed
Trust Administrator