Trust Board paper N

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: 3 November 2011

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 29 September 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 6 October 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:

- **progress in respect of hospital acquired pressure ulcers (Minute 86/11/3 refers), and**
- **concerns over the incidence of misdiagnosis in SUIs (Minute 87/11/1).**

DATE OF NEXT COMMITTEE MEETING: 27 October 2011

Mr D Tracy
28 October 2011

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MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 29 SEPTEMBER 2011 AT 9:30AM IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Miss M Durbridge – Director of Safety and Risk
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 C Ribbins – Director of Nursing/Deputy DIPAC
Mrs E Rowbotham – Director of Quality, NHS LCR
Mr S Ward – Director of Corporate and Legal Affairs
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Mr N Doverty – Divisional Manager, Clinical Support (for Minute 85/11)
Mrs S Hotson – Director of Clinical Quality
Mrs S Mason – Divisional Head of Nursing, Acute Care (for Minute 84/11)
Ms H Poestges – Researcher, KCL (observing)
Miss H Stokes – Senior Trust Administrator

ACTION

RESOLVED ITEMS

81/11 APOLOGIES

Apologies for absence were received from Mr M Caple, Patient Adviser and Mr M Wightman, Director of Communications and External Relations.

82/11 MINUTES

Resolved – that the Minutes and action sheet from the meeting held on 25 August 2011 be confirmed as a correct record.

83/11 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. Members noted in particular:--

(a) (re: Minute 73/11/2 of 25 August 2011) that the quality of patient care did not appear to have been adversely affected by the increase in staff sickness. The Chief Operating Officer/Chief Nurse advised, however, that additional staff had been required in ED and Acute Care in late August 2011 due to high levels of sickness absence in those areas, and
(b) (re: Minute 41/11/5 of 26 May 2011) plans to include appropriate SUI trend analysis/numbers in future patient safety reports to the GRMC. **DSR**

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

84/11 PATIENT STORIES DISCUSSED AT THE ACUTE CARE BOARD

Further to Minute 54/11/2 of 30 June 2011, paper C from the Acute Care Divisional Head of Nursing outlined the measures in place to share patient stories (and their associated lessons) more widely within that Division, with the aim of influencing staff behaviours and values

accordingly. A patient story (either positive or negative) was now the first item on each Acute Care Divisional Board agenda (as recommended by a Health Service Journal article on high-performing organisations). Patient stories were also discussed with both nursing and medical staff, using a variety of engagement methods and routes as detailed in paper C, including observance at complaint meetings and dedicated 1:1 sessions. It was now planned to roll-out the measures more widely within the Division, focusing particularly on the medicine CBU (as the bulk of Trust complaints related to that area).

HNAC

The GRMC welcomed the measures detailed in the report and advised sharing this approach to embedding the lessons from patient stories with other Divisions. In discussion, the Director of Nursing advised that the Divisional Heads of Nursing met weekly to discuss issues identified through patient stories.

HNAC

<u>Resolved</u> – that the Head of Nursing, Acute Care Division be requested to ensure the good practice in relation to embedding lessons from patient stories was shared with other Divisions.

85/11 THEATRES MODERNISATION PROGRAMME (TMP) UPDATE

The Divisional Manager Clinical Support attended to present an update on TMP, as circulated at paper D. The aims of the programme related to:- safety and reliability of care; improved patient experience and outcomes; value and efficiency gains, and effective teamworking and staff wellbeing. Teamworking was the fundamental enabler, and the Divisional Manager Clinical Support noted the crucial importance of the multi-disciplinary teambriefing launched approximately 12 months previously. Although use of the WHO surgical safety checklist was now at 100%, further work was needed fully to engage surgical staff in the teambriefings (this was being progressed accordingly by Clinical Support). In presenting paper D, the Divisional Manager Clinical Support also particularly noted:-

(a) the development of the 'teampack' toolkit which reinforced staff accountabilities, was reviewed through appraisal, and would aid the sustainability and further development of The Productive Operating Theatre (TPOT) initiative;
(b) the development (as a result of audit findings) of a new protocol on patient hand-over from recovery;
(c) improved stock management and stock control, leading to savings through stock reduction;
(d) the introduction of electronic "OSAG" ('operational status at a glance') boards in all main theatre areas, providing real-time information on utilisation, timekeeping and operations and taking a forward look at future voids. This was a key development in identifying and reducing inefficiencies, coupled with the crucial issue of full take-up of 4-hour theatre slots;
(e) preliminary findings from a national review of the TPOT return on investment aspects. Whilst the final report had not yet been received, the Divisional Manager Clinical Support considered that UHL had achieved the majority of the aspects, although noting that the Trust had not yet developed a financial quantum of the benefits;
(f) the key benefits in terms of improved patient experience. It was also noted that any reconfiguration of theatre sessions involved appropriate discussion with all participating services and took appropriate account of the patient experience impact, and
(g) a Clinical Support patient story presentation scheduled for the October 2011 Trust Board.

In discussion on the TMP update, the GRMC:-

(1) queried the ongoing audit plan in respect of compliance with the WHO surgical safety checklist use. The Divisional Manager Clinical Support advised that the results from the specifically-used audit tool would be reported regularly to the Clinical Audit Forum by the two clinical leads (assisted by the CASE Team). The Division recognised the need to maintain 100% compliance with the checklist and suggested repeating the audit on a quarterly basis;

DMCS

(2) queried when (and what) action would be taken in respect of any individuals not complying with the checklist. Although the TPOT initiative had now formally ended, the Division noted the role of the teampack toolkit used by band 6 nurses to evidence and monitor sustained momentum. The Divisional Manager also confirmed that appropriate action would be taken on instances of non-compliance with the checklist. In further discussion on this issue, the Medical Director advised exploring a systems-based approach in addition to audit findings – eg looking at systems to prevent a procedure going ahead unless the checklist had been performed. Although this had been explored previously the Divisional Manager agreed to revisit potential systems controls accordingly (for report to a future GRMC); **DMCS**

(3) queried how patient experience was measured in theatres. Although the patient's pre-anaesthesia interaction with the anaesthetist was taken into account, it was also noted that the Surgical Ward patient experience surveys included reference to theatres as part of the wider patient journey – that information was fed back to the theatres teams. In response to a further query on this issue from Mr P Panchal Non-Executive Director, the Divisional Manager Clinical Support clarified that his Division sought patient adviser feedback rather than from patients, although this could be reviewed;

(4) welcomed the success of the TMP and queried how its quality and financial benefits would be quantified (noting the view that the latter were linked primarily to improved utilisation rates). The Medical Director added his view that a trajectory was needed against which to measure progress on the quality benefits, with a 6-monthly update to the GRMC. Quality targets could relate to (eg) 100% compliance with the WHO surgical safety checklist. Although the financial aspects would be reported through the Finance and Performance Committee, the GRMC Chair agreed that a 6-month progress report should be provided to the GRMC; **DMCS**

(5) noted (in response to the GRMC Chair's query) Clinical Support's belief that there was scope for further improvements to utilisation rates. Work continued with colleagues in other Divisions on this issue, but changes to practice were required. Referral rates also had an impact;

(6) noted confirmation from the Divisional Manager Clinical Support that the programme of scheduled theatre closures remained on track, and

(7) queried how best the Executive Directors could assist the Clinical Support Division in sustaining and developing the improvements achieved so far. Based on the Divisional Manager's response, Executive Directors therefore agreed to visit theatres and attend some teambriefings, to reinforce the importance of such briefings and check staff understanding. **EDs**

<u>Resolved</u> – that (A) the Divisional Manager Clinical Support be requested to:- **DMCS**
(1) provide an update on TMP progress to the GRMC in 6 months' time (eg March 2012), covering:-

- **a trajectory showing progress against the quality benefits associated with the TMP;**
- **systems controls which could be introduced to prevent procedures going ahead unless the WHO surgical safety checklist had been performed;**

(2) repeat the WHO checklist audit on a quarterly basis;
(3) report to the Finance and Performance Committee on the financial benefits arising from the TMP, and

(B) Executive Directors be requested to attend some theatres team briefings, to progress the embedding of the project and check staff understanding. **EDs**

86/11 QUALITY

86/11/1 Nursing Metrics and Extended Nursing Metrics

Paper E summarised progress against the nursing metrics for the period August 2009-August 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. In respect of the extended nursing metrics (now in place within 8 specialist areas in UHL) detailed in paper E1, resuscitation checks were the key issue of amber performance, relating primarily to the documentation of such checks. UHL's work on the extended nursing metrics in theatres was being shared with Nottingham University Hospitals NHS Trust for their use, and the Chief Operating Officer/Chief Nurse advised that the November 2011 nursing journal would also be featuring an update on UHL's nursing metrics. In discussion on papers E and E1, the GRMC:-

(a) queried the number of wards on healthchecks (3);
(b) noted a query from the Chief Executive regarding progress on moving towards the real-time write-up of TTOs. In response, the Medical Director advised that e-prescribing would provide a technological system change. Junior doctors were also being encouraged to ensure that the following actions were completed before leaving their shift:- (i) checking TTOs for the next day; (ii) prescribing night analgesia, and (iii) checking the results of any investigations to see if action was needed;
(c) queried how to ensure that consistent and understandable feedback on the patient experience metrics was available to both wards and patients/visitors. In response, the Chief Operating Officer/Chief Nurse advised that a single dashboard was being launched on 30 September 2011 to provide a unified visual reference for ward performance, although acknowledging that this was aimed at staff rather than the public. Research was also underway to assess how the metrics were changing staff behaviours and impacting positively on patient experience. The Director of Nursing noted that all Releasing Time to Care wards publicly displayed boards showing performance. An update on the UHL 10 point plan was also being provided to the October 2011 Trust Board meeting. The Chief Operating Officer/Chief Nurse agreed to give further thought to how best to communicate the nursing metrics information to both staff and the public – in further discussion on this, Ms J Wilson, Non-Executive Director noted that any additional information developed should supplement – rather than replace – the report at paper E; **COO/ CN**
(d) voiced concern at the amber performance on the resuscitation checks metric, and
(e) queried why the extended nursing metrics did not feature in the monthly quality finance and performance report. In response, the Chief Operating Officer/Chief Nurse advised that these were included in the Divisional heat map report, of which all Non-Executive Directors received a copy.

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

(B) the Chief Operating Officer/Chief Nurse be requested to explore how best to communicate/highlight the information from the metrics to staff and the public in a meaningful way. **COO/ CN**

86/11/2 Quality Finance and Performance Report – Month 5

Papers F and F1 detailed the quality, finance and performance report and heat map for month 5 (month ending 31 August 2011). The Chief Operating Officer/Chief Nurse particularly noted:-

(i) that UHL was still working through the appeal mechanism in respect of specific MRSA bacteraemia case(s);

(ii) national changes to the performance measures in respect of ED;

(iii) her plan to submit a detailed review of falls issues to the October 2011 GRMC (as per that already done for pressure ulcers) in order to understand and therefore address current variances, and **COO/ CN**

(iv) that the patient experience table on page 15 of the main quality finance and performance report now included an additional column indicating the (positive) impact of removing the scores from specific underperforming medical wards (not all medical wards). In discussion on this point, the GRMC Chair queried the factors behind those wards' underperformance – in response, factors were thought likely to include leadership issues, capacity, capability, patient acuity etc. Although there were no immediate patient safety concerns, the situation would continue to be closely monitored, and additional Matron and Lead Nurse-level support had also been placed in Medicine. In response to a query from the Medical Director, the Chief Operating Officer/Chief Nurse advised that the current scores in those underperforming medical wards indicated a significant dip against previous medicine performance – the Chief Executive commented on the need for further analysis of the underlying factors, including the strength of overarching management support in medicine and any other contextual aspects. The Chief Operating Officer/Chief Nurse also agreed to identify the specific wards in question outside the meeting. **COO/ CN**

In respect of the quality sections of the month 5 report, the Medical Director drew members' attention to the apparent increase in UHL's elective RAMI (risk adjusted mortality indicator) – following a review 9 of the apparent 26 elective patients had been found to have been emergencies; the resulting figure of 17 was therefore in line with month 4 levels. The Medical Director noted his disappointment at this coding error (which repeated an issue from the previous year and had been re-flagged accordingly to the coders), as he had been previously been assured that processes were in place to prevent a recurrence. The Medical Director also welcomed UHL's achievement of the majority of the CQUINS and noted continuing improvements to VTE risk assessment recording. He also briefly outlined the nature of the incident referred to in section 3.6 of the covering report to paper F, confirming that there had been no patient harm but that lessons had been learned.

In further discussion on the month 5 quality finance and performance report the GRMC:-

(a) queried whether any particular trends/themes or repeat offenders were being indicated by the healthcheck. The Chief Operating Officer/Chief Nurse commented that all of the repeat offenders were medical wards and she confirmed that all such repeat areas were reviewed closely and re-audited. No specific themes had emerged to date. The GRMC Chair advised that it would be helpful for the GRMC to receive a report on the findings of those repeat frequency audits; **COO/ CN**

(b) noted concerns voiced by Mr P Panchal, Non-Executive Director, at the % of patients not being able to find staff with whom to discuss their worries and fears (patient experience metrics), even though those levels were still rated as green (as they were measured against nationally-set targets). UHL was taking action to improve performance on patient experience indicators through its various Divisional projects. In discussion, the Director of Quality NHSLCR suggested it would be helpful also to include local CQUIN targets in the patient experience table on page 15 (against which targets UHL was also green); **COO/ CN**

(c) noted (in response to a query from Ms J Wilson, Non-Executive Director) that appropriate lessons from the never event were also being taken forward with primary care colleagues, and

(d) noted the action taken with the CQRG to resolve the shortfall on the stroke CQUIN, as now outlined by the Chief Operating Officer/Chief Nurse.

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

(B) the Chief Operating Officer/Chief Nurse be requested to:- **COO/ CN**

(1) present a detailed review of falls to the 27 October 2011 GRMC;
(2) submit information from the repeat frequency audit findings (re: healthcheck wards) to a future GRMC;
(3) identify the specific underperforming medical wards to GRMC members outside the meeting;
(4) review the contextual factors surrounding those underperforming medical wards, including overall CBU-level management support, and
(5) include the local CQUIN target re: patient experience (Divisional projects table on page 15), in future iterations of the monthly QFP report.

86/11/3 Update on Hospital Acquired Pressure Ulcers (HAPUs)

Further to Minute 73/11/7 of 25 August 2011, paper G provided benchmarking information on HAPUs. Based on FOI data from a number of comparable sized acute Trusts, the report provided assurance that UHL was not an outlier in terms of the incidence of hospital acquired pressure ulcers and noted good progress in reducing the number of grade 3 and 4 HAPUs reported within UHL. The Chief Operating Officer/Chief Nurse noted previous differences in UHL's reporting of HAPUs compared to practices elsewhere, and also advised the GRMC that UHL was now involved in research work on HAPUs with the Department of Health, AUKUH, De Montfort University and two other NHS Trusts. She also noted that future UHL reports would differentiate between the various grades of HAPUs, to enable more appropriate benchmarking.

Welcoming this update, the GRMC noted a query from Ms J Wilson, Non-Executive Director, as to whether patients were more susceptible to HAPUs in winter and whether a coming spike should therefore be pre-empted. In response, the Chief Operating Officer/Chief Nurse commented that a greater number of frail elderly patients were admitted in winter, who were themselves more susceptible to pressure ulcers. The Director of Quality NHSLCR considered that there was not yet sufficient data on this issue to identify a statistical seasonal variation. In further discussion on this point, the Medical Director sought a view from Commissioners on how they saw their role in progressing the development of community-wide statistics on HAPUs – in response, the Director of Quality NHSLCR confirmed that specific CQUIN questions were asked and noted PCTs' request for Leicestershire Partnership NHS Trust to use the same reporting documentation and methodology as UHL in an effort to standardise as far as possible. Commissioners were also keen to share UHL good practice on HAPUs more widely across LLR. The Chief Operating Officer/Chief Nurse advised that those AUKUH Trusts involved in the aforementioned research project were also planning to monitor HAPU data in the same way as UHL. In response to a query, it was advised that the data in paper G had been shared with PCT Non-Executive Directors through the quality meeting earlier that morning. The Chief Operating Officer/Chief Nurse also confirmed that from January 2012 onwards she would provide a quarterly report to the GRMC on comparative HAPU data, taking appropriate account of the research project and other benchmarking initiatives. **COO/ CN**

The Chief Executive welcomed the good work within paper G and commented on the need for UHL to take a national leadership role in raising the profile of pressure ulcers. It was agreed that the Trust's work on improving the incidence of hospital acquired pressure ulcers within UHL (and assurances gained through the other initiatives listed in paper G) would be highlighted to the Trust Board via these Minutes. **GRMC CHAIR**

<u>Resolved</u> – the (A) the update on hospital acquired pressure ulcers be noted;

(B) the Chief Operating Officer/Chief Nurse be requested to provide a comparative performance report (with partner organisations) re: hospital acquired pressure ulcers, to the GRMC on a quarterly basis beginning from January 2012, and **COO/ CN**

(C) the GRMC Chair be requested to highlight the assurance received from the work to

date on pressure ulcers, to the 6 October 2011 Trust Board via the GRMC Minutes. **GRMC CHAIR**

87/11 SAFETY AND RISK

87/11/1 Patient Safety Report

Paper H from the Director of Safety and Risk advised the GRMC of quarter 1 safety data (re: incidents, complaints, claims and inquests reported from 1 April – 30 June 2011), ongoing NPSA alerts with an expired deadline as of August 2011, the Price Waterhouse Coopers review of UHL action plans relating to serious untoward incidents (SUIs), SUIs reported in August 2011, Executive safety walkabouts, and 60-day root cause analysis (RCA) performance. The Director of Safety and Risk drew members' particular attention to the following points:-

(a) work in progress to address the quarter 1 dip in performance on 60-day complaint response timescales (re: Facilities complaints);
(b) work in progress to triangulate information on complaints/claims/incidents/inquests and extract relevant learning;
(c) intended trend analysis of SUI figures in respect of patient safety incidents (Minute 83/11 above refers). Data for the last 4 months indicated the following numbers:- 6 (June 2011), 1 (July 2011), 7 (August 2011) and 0 (September 2011);
(d) actions to resolve the 4 ongoing NPSA alerts with an expired deadline, as detailed in section 3 of the patient safety report. The chest drain alert would be closed off following a further scheduled report to the October 2011 QPMG;
(e) her intention to submit PwC's report on the Trust's SUI action plans to the GRMC once received; **DSR**
(f) of the 15 SUIs in August 2011, 7 had related to patient safety. Misdiagnosis was increasingly emerging as an issue, and the Director of Safety and Risk was meeting with the Associate Medical Directors to discuss further monitoring of this situation. Undergraduate and postgraduate teaching was also being reviewed, although as yet no common element was apparent from the misdiagnoses. The Chief Executive requested that this issue be highlighted to the October 2011 Trust Board through these Minutes, and **GRMC CHAIR**
(g) the mostly positive comments reported through the Executive safety walkabouts. Awareness of/identification with CIP nomenclature was emerging as a possible issue, particularly in respect of junior staff. Information from the walkabouts was shared both internally and externally (with PCTs).

In discussion on the patient safety report the GRMC noted:-

(1) a query from Mr P Panchal, Non-Executive Director, as to why patients could take their hospital prescription only to the hospital pharmacy. In response (and in addition to noting the complex VAT and financial arrangements surrounding hospital prescriptions) the Medical Director outlined a pilot exercise about to start with a commercial pharmacy chain re: outpatient prescribing;

(2) the Chief Executive's concerns over increasing waiting times in the Planned Care Division, and his request that this situation be carefully tracked. The Director of Safety and Risk also noted discussions with Planned Care's Divisional Manager and Head of Nursing to improve that Division's complaints performance; **DSR**

(3) a query from Mr P Panchal, Non-Executive Director, as to whether evening/night Executive safety walkabouts could be scheduled. A number of other out-of-hours walkabouts were already done by the Chief Operating Officer/Chief Nurse and the Director of Nursing, who agreed to consider the most appropriate way of reflecting that resulting information in future updates. Due consideration would also be given to scheduling some evening/night Executive walkabouts as suggested, and the current evening rota could be shared with GRMC members for information; **COO/ CN/DN**

(4) a request from Ms J Wilson, Non-Executive Director, as to whether any benchmarking data or targets were available, to provide greater reassurance on UHL's complaints performance. The Director of Quality NHSLCR noted that the quality schedules included metrics and thresholds in respect of complaints, and agreed to share these with GRMC members. NHS Information Centre annual benchmarking information on Trust complaints was also available. The Director of Safety and Risk also noted her ongoing discussions with all UHL Divisions re: complaints performance improvement plans. The GRMC Chair requested that complaints benchmarking information be presented to the November/December 2011 GRMC meeting, to coincide with Women's and Children's Division attending to present their annual complaints performance, and — **DQ NHS LCR/ DSR** — **DSR**

(5) comments from Professor D Wynford-Thomas, Non-Executive Director, that the inclusion of different styles of charts/tables in the report was not helpful. He suggested that figure 8 on page 12 of paper H was key (indicating trend data on complaint themes/subject areas). He also requested 3 years' contextual data to make the information more meaningful. — **DSR**

Resolved – (A) the patient safety report be noted;

(B) the Director of Safety and Risk be requested to:- — **DSR**
(1) keep issues arising from Planned Care waiting times under appropriate review;
(2) present the PwC report on UHL SUI action plans to a future GRMC, once available;
(3) pursue her discussions with the Associate Medical Directors re: misdiagnosis elements of August 2011 SUIs;
(4) circulate the NHS Information Centre annual benchmarking figures re: complaints to GRMC members for information;
(5) review the formatting of the various charts in the patient safety report, for increased ease of navigation, and consider including more contextual 3-year information;
(6) present a report on complaints benchmarking to the November/December 2011 GRMC to coincide with the next Divisional complaints (annual performance) presentation;

(C) the Director of Quality, NHSLCR be requested to share the quality schedule metrics/thresholds re: complaints performance, with GRMC members for information; — **DQ NHS LCR**

(D) the Chief Operating Officer/Chief Nurse and the Director of Nursing be requested to consider scheduling some evening/weekend Executive Safety Walkabouts, or including feedback from their own out-of-hours walkabouts in the updates to future GRMC meetings, and circulate the evening/night rota details to GRMC members for information, and — **COO/ CN/DN**

(E) the GRMC Chair be requested to highlight concerns over misdiagnosis elements of August 2011 SUIs to the 6 October 2011 Trust Board via the GRMC Minutes. — **GRMC CHAIR**

87/11/2 5 Critical Safety Actions – Structured Engagement Plan and Dissemination

Paper I advised the GRMC of engagement and dissemination activities in respect of the 5 critical safety actions. Leads had been identified for each action and were working on individual, comprehensive action plans, and the 5 critical safety actions were also being built into the teaching and training sessions for junior doctors. As previously reported, each GRMC meeting would receive an update on a different critical safety action (Minute 87/11/3 below also refers).

Resolved – that the update on engagement and dissemination work in respect of the 5 critical safety actions, be noted.

87/11/3 Implementing and Embedding Mortality and Morbidity Standards

The implementation and embedding of mortality and morbidity standards was one of the 5 critical safety actions, and the Director of Safety and Risk noted work in progress to standardise the mortality and morbidity (M&M) meetings across UHL's various specialties, with a greater focus on avoidable deaths, SUIs and clinical care complaints. Both Dr B Collett, Associate Medical Director Clinical Effectiveness and the Director of Safety and Risk planned to attend some M&M meetings to critique current practice. An M&M form had also been developed, feedback from which was reported to the monthly UHL Clinical Effectiveness Committee meetings. UHL's Mortality and Morbidity Reviews Policy had also been updated.

Resolved – that the verbal update on implementing and embedding mortality and morbidity standards be noted.

87/11/4 Report by the Director of Safety and Risk

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal data.

87/11/5 PHSO Complaint Analysis Report

Paper L from the Director of Safety and Risk set out the UHL-related findings of the Parliamentary and Health Service Ombudsman's (PHSO) analysis of NHS Trust complaints. The PHSO's analysis had been followed by a visit to Trusts, and the positive outcome of that 'Trust Liaison Visit' to UHL (19 September 2011) was also detailed in paper L. As noted in section 2.2 of the report, the PHSO had commented on UHL's "excellent" complaints handling process and its PILS service, and noted that UHL compared favourably to peer Trusts in terms of the number of referrals to the PHSO. Paper L also outlined a number of areas on which the Director of Safety and Risk had sought information from the PHSO Team, including the handling of difficult and persistent complainants and how to engage better with all areas of the community. Although no areas for immediate action (nor of significant concern) had been raised by the PHSO in respect of UHL's complaints handling, the following were outlined in paper L as potential areas for further improvement:-

(i) ensuring all actions were proportionate, and
(ii) ensuring that personal, organisational and financial remedy was considered for each complaint.

In response to a query from the Director of Corporate and Legal Affairs, the Director of Safety and Risk confimed that she would progress the actions above in conjunction with UHL's Divisions and the Head of Legal Services. In response to a query from Mr P Panchal, Non-Executive Director, it was confirmed that this was the first such report received from the PHSO. The Director of Safety and Risk also advised that out of approximately 1400 written and 700 verbal complaints annually, UHL had gone on to have only 1 complaint upheld by the PHSO in 2010-11. **DSR**

Resolved – that (A) the positive findings from the PHSO complaints analysis in respect of UHL be noted, and

(B) the areas for further action identified above at (i) and (ii) be progressed by the Director of Safety and Risk in conjunction with UHL Divisions and the Head of Legal Services. **DSR**

87/11/6 Learning from Clinical Negligence Claims

The Director of Safety and Risk confirmed that clinical negligence claim reports were carefully reviewed to glean any learning from their recommendations. A proforma had also been developed to capture learning appropriately from previous incidents/complaints prior to reaching claim stage, and issues identified were followed up with the relevant Division(s). Although this was more difficult in cases where claims had not previously been either a complaint or an incident, key themes from such cases were still reviewed. The revalidation process for medical staff also identified claims/complaints/incidents for individual doctors.

Mr P Panchal, Non-Executive Director, noted that it would be helpful for the GRMC to receive information on settled claims, and the Director of Safety and Risk agreed to incorporate an appropriate narrative into future patient safety reports. The Director of Corporate and Legal Affairs advised that the NHS Litigation Authority (NHSLA) was also interested in drawing out lessons from claims – that body had requested information from NHS Trusts and would report accordingly later in 2011. Once received, it was agreed that the NHSLA report should be presented to the GRMC. **DSR** **DCLA**

Resolved – that (A) the process for learning from clinical negligence claims be noted;

(B) (in conjunction with the Director of Corporate and Legal Affairs) the Director of Safety and Risk be requested to expand future iterations of the patient safety report to include a narrative on settled claims, and **DSR**

(C) the Director of Corporate and Legal Affairs be requested to present the NHSLA report on lessons from claims to a future GRMC meeting, once available. **DCLA**

87/11/7 Safeguarding Case Reviews

The Chief Operating Officer/Chief Nurse advised that there was nothing to report under this item.

Resolved – that the position be noted.

88/11 ITEMS FOR NOTING

88/11/1 UHL Health and Safety Report

Resolved – it be noted that the UHL Health and Safety Report for the period July 2011 – December 2011 would be presented to the 4 January 2012 GRMC meeting. **DSR**

88/11/2 Keogh Dashboard

Resolved – that the update on the position regarding the Keogh dashboard proposal, be noted as detailed on the agenda for this meeting.

89/11 MINUTES FOR INFORMATION

89/11/1 Finance and Performance Committee

Resolved – that the Minutes of the 24 August 2011 Finance and Performance Committee meeting (paper M) be received for information.

90/11 ANY OTHER BUSINESS

There were no items of any other business.

91/11 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 6 October 2011 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

(1) progress in respect of hospital acquired pressure ulcers (Minute 86/11/3 above refers);
(2) concerns over the incidence of misdiagnosis in SUIs (Minute 87/11/1 above refers), and
(3) the issues discussed in confidential Minute 87/11/4 above.

92/11 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 27 October 2011 from 1pm in Conference Rooms 1A&1B, Gwendolen House, LGH site.

The meeting closed at 11.50am

Helen Stokes
Senior Trust Administrator