Trust Board paper M

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 6 October 2011

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 25 August 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 1 September 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 PUBLIC CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- **discussion on the quality and safety monitoring of current CIP schemes (Minute 72/11/2 refers), and**
- **discussion on the review of the prevention, management and reporting of Hospital Acquired Pressure Ulcers (Minute 73/11/7 refers).**

DATE OF NEXT COMMITTEE MEETING: 29 September 2011

Mr D Tracy – Non-Executive Director and GRMC Chair
29 September 2011

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 25 AUGUST 2011 AT 9:30AM 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)
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
Ms C Trevithick – Associate Director of Quality, NHS Leicestershire County and Rutland (LCR) (on behalf of Mrs E Rowbotham, Director of Quality, NHS LCR (non voting member))
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Ms J Ball – Divisional Head of Nursing, Planned Care (for Minute 74/11/5)
Dr B Collett – Associate Medical Director, Clinical Effectiveness (for Minute 74/11/5)
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Ms T Pender – Clinical Coding Project Manager (for Minute 72/11/1)
Mr J Roberts – Assistant Director of Information (for Minute 72/11/1)

RESOLVED ITEMS **ACTION**

70/11 APOLOGIES

Apologies for absence were received from Miss M Durbridge, Director of Safety and Risk; Mrs E Rowbotham, Director of Quality, NHS LCR and Mrs C Ribbins, Director of Nursing/Deputy DIPAC.

71/11 MINUTES

Resolved – that the Minutes of and action sheet from the meeting held on 28 July 2011 be confirmed as a correct record.

72/11 MATTERS ARISING REPORT

The Committee Chair confirmed that the matters arising report (paper B) both highlighted the matters arising from the meeting held on 28 July 2011 and provided an update on any outstanding matters arising from the GRMC meetings held since October 2009. Discussion took place regarding the following item:-

(a) in respect of Minute 64/11, Mr P Panchal, Non-Executive Director requested that an action plan further to engagement events with ethnic minority groups to ascertain their views in respect of patient experience surveys be presented to the GRMC in November 2011. **DoN**

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

72/11/1 Clinical Coding – Encoder Implementation

The Assistant Director of Information and the Clinical Coding Project Manager attended the meeting to present paper C, an update on progress with the clinical coding project. It was noted that the project had been extended to include coding of outpatients (previously it was limited only to inpatients and daycases). A project board had been established which included Commissioner and GP representation and would be chaired by the Chief Operating Officer/Chief Nurse.

Members noted that there had been excellent clinical engagement in this project. In response to a query from the Director of Communications and External Relations, members were advised that Clinicians wanted to ensure that the information released showed a correct interpretation of the activity taking place. They were also genuinely interested in providing accurate information in the patients' health records which aided in driving clinical quality and improved outcomes. The Medical Director re-iterated that the information released by the clinical coding team had created an interest amongst the Clinicians.

The Assistant Director of Information advised that five areas had been identified to optimise coding across the Trust and the coding workforce allocation for these areas had been re-aligned. A real time coding resource would be provided so that coding could be completed in conjunction with the Clinician either at discharge or at ward round to ensure complete and accurate coding took place. A clinical coding scorecard was being developed to demonstrate the baseline and impact of improvements in coding, and to identify potential lost income.

The Trust had procured an electronic encoder, 'Medicode', a software package that clinical coders would use to assist in recording accurate and complex coding, thereby reducing the amount of time to search through the current clinical coding manuals. It was noted that due to upgrade issues to Patient Centre, the implementation date of Medicode had been delayed to 3 October 2011. The Cardiology Clinicians had expressed an interest to pilot this system to code their activity and the clinical coders would provide the assurance role. Professor D Wynford –Thomas queried the reason for a clinical coder to provide an assurance role – in response, it was noted that though Medicode would assist Clinicians to code, there were some protocols that needed to be followed and the clinical coder would need to assure that the codes were valid. However, in the long term, the clinical coders' role would be changed to provide an audit function.

Responding to a query from the Patient Adviser, it was noted that the clinical coding system would prompt Clinicians to include robust information in patients' notes and the coding project had been linked with the discharge letter project which would thereby provide a complete and timely discharge letter to the patient.

Responding to another query, it was noted that though some risks and issues had been logged relating to this project, there were no patient safety risks that had been identified.

In response to a query in respect of linking all IT systems within the Trust, it was noted that currently there were different systems in place, however, developing an electronic patient record was within IM&T's long-term business plan. The Chief Executive re-iterated that the integration of systems had been covered in the IM&T strategy.

The Chief Operating Officer/Chief Nurse commended the work of the Assistant Director of Information and the Clinical Coding Project Manager for the engagement work undertaken with Clinicians to kick-start this project. The Committee Chairman suggested that an update report on clinical coding be provided to the GRMC (for **ADI**

information) in November 2011.

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

(B) the Assistant Director of Information be requested to present an update report on clinical coding (for information) to the GRMC in November 2011. **ADI/TA**

72/11/2 Quality and Safety Monitoring of Current CIP Schemes

The Committee Chairman and Ms J Wilson, Non-Executive Director expressed concern that the format of CIP risk assessments of quality and safety (papers D-D4 refer) was different across all Divisions and suggested that a standard format would be preferable. There also seemed to be inconsistency in the sign-off of the risk assessments. The Committee Chairman commented that some of the actions were robust however many others were indicated as 'on-going' and noted the need for specific dates/month to be included. The Chief Operating Officer/Chief Nurse advised that the Divisions completed the risk assessments and provided the initial sign-off which was then sent to the Risk and Assurance Manager. However, she advised that a Project Management Office was being established and would be required to sign-off documentation in order to provide a consistent approach. If any high risk issues were identified in the risk assessment, then Divisions would be required to provide additional information. **COO/ CN**

The Associate Director of Quality, NHS LCR advised that their Quality & Clinical Governance Committee were particularly interested in progress relating to risks in patient safety. The Chief Executive highlighted that the actions agreed by the Divisions should be completed as indicated by them.

Resolved – that (A) the contents of papers D- D4 be received and noted, and

(B) further to the establishment of a Project Management Office in August/September 2011, the GRMC at its meeting in October 2011 to seek assurance that the patient safety/quality of care indicators in respect of risks associated with the Divisional CIP schemes were being adequately monitored. **COO/ CN/TA**

73/11 QUALITY

73/11/1 Nursing Metrics and Extended Nursing Metrics

The Chief Operating Officer/Chief Nurse presented paper E, a summary of nursing metrics performance for July 2011, noting continued progress to maintain positive or developing performance since June 2011. Out of the 13 metrics in place, 10 scored 'green', 2 'amber' and ' 1 'red'. The key focus was being given to improve the discharge planning metric. This complemented the discharge planning work-stream led by the Emergency Care Network where monthly reporting was being undertaken on:-

(a) Estimated Date of Discharge;
(b) TTOs completed prior to discharge, and
(c) daily ward rounds.

Paper E1 detailed the implementation of a range of nursing care metrics in the specialist areas within UHL. The Chief Operating Officer/Chief Nurse advised that the resuscitation compliance in theatres remained unsatisfactory noting that though the resuscitations checks were undertaken, if all components were not completed then a 'red' scoring would be given. The Director of Corporate and Legal Affairs suggested the need for compliance with the resuscitation indicator to be extended to all specific areas and not only theatres. It was confirmed that formal action would be

taken for any continued non-compliance in respect of this indicator.

Responding to a query, it was noted that considerable work had not been done to interpret a correlation between patient satisfaction rate and the Central Booking System (CBS) (noting the higher patient satisfaction rate for patients accessing services at the Glenfield Hospital site which had a CBS in place). The Chief Operating Officer/Chief Nurse highlighted that there might be a number of contributory factors to improve patient experience and the roll-out of outpatient polling would provide a clear picture on this.

Ms J Wilson, Non-Executive Director queried whether new indicators would be included if any indicators remained 'green' for a considerable period of time – in response, the Chief Operating Officer/Chief Nurse advised that instead of including new indicators, the subsets within the current indicators would be expanded thereby allowing staff to remain focussed.

Resolved – that the contents of the nursing metrics and extended nursing metrics reports (papers E & E1 refer) be received and noted.

73/11/2 Quality and Performance Report – Month 4

The Chief Operating Officer/Chief Nurse presented papers F and F1, the quality, finance and performance report and heat map for month 4 (month ending 31 July 2011). The following points were highlighted in particular:-

- the outpatient cancellation by hospital stretch target was 10.5%;
- the change in the theatre utilisation target which now looked at 4 hour operating sessions, and
- improved performance in relation to most of the performance indicators.

Responding to a query, the Chief Operating Officer/Chief Nurse advised that an update on the Caring at its Best Divisional projects would be presented to the GRMC in October 2011. **DoN**

Ms J Wilson, Non-Executive Director queried if there were any specific factors which related to the increase in the number of falls in March 2011 in the Planned Care Division (noting that there had been an overall reduction in reported falls for April – June 2011) and whether any lessons could be learnt prior to the winter period – in response, it was noted that work was underway to look into numbers of falls (i.e. patient numbers and multiple falls of a single patient) and the causation (i.e. medication related, dementia etc). It was noted that falls were reported on DATIX and the numbers were retrospectively changed if it was not considered as a SUI. The Chief Operating Officer/Chief Nurse recommended that falls reporting should be undertaken a month in arrears to allow for CBUs to close the DATIX reports which would enable accurate reporting of numbers – the Committee agreed to this approach.

In response to a query from Mr P Panchal, Non-Executive Director, it was noted that the response time of staff for each fall was not necessarily always investigated, however, the causation of the fall was explored. In respect of planning for the winter months, members were advised that the nurse to bed ratios were being re-examined specifically given the higher acuity of patients in the Medicine CBU.

The Medical Director advised that the 'crude' overall mortality rate and the elective mortality rate remained constant whilst there had been a slight fall in the mortality rate for emergency admissions. The quality of inpatient discharge letters had significantly improved. An audit of the outpatient letters had identified two areas (copying letters to patient and timing of letters) for improvement. However, a

standard approach had now been agreed and Services were required to ensure that letters were sent to patients within 10 days of their clinic appointment.

Members noted that 75% of patients with fractured neck of femur were taken to theatre within 36 hours during July 2011.

The Medical Director confirmed that advice had been sought from the SHA and UHL would now include haemodialysis patients in the VTE risk assessment data as a cohort (this was in line with other Trusts' practice), this had therefore increased UHL's performance to 90% and thereby no financial penalties would be implemented.

It was noted that despite an increase in the volume of readmissions in June 2011, the overall trend in readmissions in 2011 had been low. Initially, UHL appeared an outlier compared to other Trusts. However, a further review had identified that this was predominantly due to the way some other Trusts counted admissions but when compared with individual 'like' hospitals, the readmission rates were similar. A review previously piloted in the Planned Care Division was now being rolled out across all bed holding wards which would highlight any patients wrongly coded or who were otherwise exempt from the 'Readmissions Penalty'. The Medical Director advised that there was enthusiasm from Clinicians to resolve issues relating to readmissions.

In response to a query from the Director of Communications and External Relations, the Medical Director advised that in the method of calculating readmissions, the denominator used by some Trusts was different which thereby brought about differences in the percentage. The Committee Chairman also noted the reporting differences in other areas (i.e. VTE risk assessment, pressure sores) which were actually proving to be a disadvantage for UHL. The Medical Director acknowledged this but noted that the project infrastructure had been reviewed and amended and aimed to achieve 25% reduction in readmissions by March 2012. There were other pilots taking place across the Trust to reduce readmissions and were in line with best practice. The Medical Director noted that considering the quality aspects there was an absolute requirement to treat patients in the best possible way. He re-iterated that the project was pursuing a number of quality initiatives and applying checks to drive down patients who were being re-admitted. Members noted that wider developments such as development of Acute Physicians and the Frail Elderly Unit would also support the reduction of readmissions.

In further discussion on re-admissions, re-ablement and changing practices in the Community, the Chief Executive agreed to liaise with the Emergency Care Network in respect of improving the overall LLR emergency care system and provide an update to the Finance and Performance Committee in October 2011. **

** *Post meeting note*: This has been superseded by discussion at the Trust Board development session on 1 September 2011.

In relation to patient safety aspects, the July figures demonstrated an expected reduction in the daily average outlying figure to the lowest level for 12 months. Divisions/CBUs continued to focus on the quality of complaint responses and a reduction in re-opened complaints had been noticed, with clear plans developed to continue this reduction over the months ahead.

There had been a marked increase in the number of incidents reported relating to staffing levels specifically in the labour wards and neonatal units, however, it was noted that though staffing levels were considered safe, staff were pressurised due to the complexity of the cases rather than the volume of patients. The Chief Operating Officer/Chief Nurse advised that this issue was also discussed at the Divisional

Confirm and Challenge meeting and the Women's and Children's Division had agreed to cascade information to their CBUs that the incident forms should record information on whether staffing levels were safe or not.

The Trust sickness rate had increased from 3.6% in June 2011 to 4.02% in July 2011. In response to a query from Mr P Panchal, Non-Executive Director on whether the increase in staff sickness would affect the quality of care of patients, the Chief Executive requested Executive Directors to check this during their safety and releasing time to care walkabouts and also at the weekly metrics meeting. It was also noted that the Director of Human Resources was assessing the reasons for the increase in short term absences. **GRMC EDs**

<u>Resolved</u> – that (A) the quality and performance report and divisional heat map for month 4 (month ending 31 July 2011) (papers F and F1) be received and noted;

(B) the Director of Nursing be requested to present an update on the Caring at its Best Divisional projects at the GRMC meeting in October 2011, and **DoN/TA**

(C) the Executive Directors of the GRMC be requested to check during their safety walkabouts, whether the increase in staff sickness had affected the quality of care of patients. **GRMC EDs**

73/11/3 <u>Quality Accounts 2010-11 - External Assurance</u>

The Director of Clinical Quality presented paper G, a report on a review (dry run exercise) of 2010-11 quality accounts by the Trust's External Auditors (KPMG). It was noted that this report had been presented to the Executive Team at its meeting on 16 August 2011. Further to comments from the GRMC, this report was scheduled to be presented to the Audit Committee in September 2011.

The findings of the review were:-

(a) the Trust would need to make only minor improvements to the overall arrangements for preparing and publishing the quality account in order to seek a limited assurance opinion in future periods, and

(b) minor improvements need to be made to the processes for assuring the quality of data underpinning the specified performance indicators in order to seek a limited assurance opinion in future periods.

Responding to a query from the Committee Chairman, it was noted that in future years, the form of external assurance on NHS Trusts' quality accounts might take the form of a limited assurance opinion, subject to further confirmation from the Department of Health. The Director of Clinical Quality advised that the quality accounts indicators would be reported and monitored through the Quality and Performance report. It was noted that planning had already begun for the 2011-12 quality accounts.

<u>Resolved</u> – the contents of paper G be received and noted.

73/11/4 <u>VTE Risk Assessment CQUIN - Progress Update</u>

<u>Resolved</u> – that this item had been discussed under Minute 73/11/2 above.

73/11/5 <u>Quarterly Report from Clinical Audit Committee and Clinical Audit Dashboard</u>

Further to Minute 54/11/1 of 30 June 2011, the Director of Clinical Quality presented

paper H, a progress report against UHL's clinical audit programme and dashboard. The Clinical Audit Committee (chaired by the Director of Clinical Quality) received a quarterly report on progress against the clinical audit programme aligned to the prioritisation process for clinical audit to ensure that there was a balance between mandatory and division/service requirements. The clinical audit dashboard had been designed to summarise the clinical activity within the Trust and highlight areas of good practice and also areas of improvement beyond the Clinical Audit Committee (CAC).

Paper H outlined the details on progress with delivering the UHL Clinical Audit Programme and an update with regards to implementing actions agreed as a result of the clinical audits undertaken with the Trust. The Director of Clinical Quality highlighted that it had been challenging to summarise all of this information in a dashboard. The clinical audit action plan would be signed-off only if all actions were completed. Members were advised of a minor amendment noting that the total number of active audits registered to the Clinical Support Division was 104 and not 74 as specified in the paper thereby bring the total number of audits to 674.

In response to suggestions, the Director of Clinical Quality agreed to ensure that a 'RAG' rating column was included in the dashboard to indicate the status of the 'audits with actions outstanding' and a brief synopsis of 'red' rated audits. Members were advised that a clinical audit summary report had been presented to Commissioners and one concern raised by them was currently being followed-up. **DCQ**

In response to a query from Mr P Panchal, Non-Executive Director in respect of outliers being reported, it was noted the CAC considered this at its monthly meetings. The CAC also discussed whether the clinical audits had identified any clinical risks and whether the actions plans would address these risks.

The Director of Communications and External Relations expressed concern on the processes in place to make the GRMC aware of any clinical risks/issues etc. He drew members' attention to appendix 3 of paper L - NIPAG Annual Report 2010-11 where the TAVI procedure (audit details) was rated ‘amber’. In response, it was noted that the CAC and NIPAG reported to the Trust's Clinical Effectiveness Committee (CEC) and a quarterly summary report on all open 'notifications' was considered by the CEC. In further discussion on this matter, the Director of Corporate and Legal Affairs highlighted that the GRMC received a quarterly report from the CEC and suggested that in the longer term, a narrative on the qualitative assessment of the work from the CEC should be included as part of the Quality and Performance report. **MD**

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

(B) within the next quarterly report from the Clinical Audit Committee, the Director of Clinical Quality be requested to ensure that a 'RAG' rating column be included in the dashboard to indicate the status of the 'audits with actions outstanding' and a brief synopsis of 'red' rated audits, and **DCQ/TA**

(C) the Medical Director be requested to present the quarterly report from the Clinical Effectiveness Committee to the GRMC in October 2011 and in the longer term, a narrative on the qualitative assessment of the work from the CEC should be included as part of the Quality and Performance report, as appropriate. **MD/TA**

73/11/6 <u>CQUIN Scheme 2011-12 - Quarter 1 Performance</u>

Paper I outlined the performance for 2011-12 quarter 1 against the quality schedule and CQUIN scheme indicators. The Trust was being monitored on 193 indicators as

part of the 2011-12 contract. The Chief Operating Officer/Chief Nurse advised that the Trust was required to report on 145 of the quality schedule/CQUIN indicators either to East Midlands Specialised Commissioning Group or the PCT's Clinical Quality Review Group. Section 2 of the paper detailed the anticipated 'RAG' rated performance of these indicators.

Clinicians had voiced concerns regarding the detail of action/delivery and further discussion to resolve these issues had taken place. The reconciliation meeting (chaired by the Associate Director of Quality, NHS LCR) had raised the following issues:-

(a) in 2011-12, 50% of the remuneration would be held back pending reconciliation which would therefore affect the liquidity position (members noted that in 2010-11, 10% was held back), and

(b) the timing of sign-off - with the recent changes to the Commissioner roles and involvement of GPs, there was a need to engage all parties prior to sign-off.

The Associate Director of Quality, NHS LCR expected to be in a position to reconcile the majority of the indicators noting that it had been a learning curve for GPs. She noted the need for accurate information for quarter 1 (2011-12) in order to improve over the year. The Committee Chairman noted that the 'RAG' rating column in the table within section 4 of the report would need to be adjusted for VTE risk assessment advising that there would be no financial penalty to the Trust (Minute 73/11/2 above refers).

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

73/11/7 Update on Hospital Acquired Pressure Ulcers

The Chief Operating Officer/Chief Nurse provided a verbal update on this item noting that UHL's reporting methodology of pressure ulcers was slightly different from other Trusts. With the support from Commissioners, UHL had recently reviewed how it classified pressure ulcers and had agreed to differentiate between all grades of avoidable and unavoidable pressure ulcers using Department of Health guidance**.** She noted that it had been challenging to obtain benchmarking information on acute pressure ulcers, however indicative figures of 5 other Trusts (anonymous) was provided. UHL had reported 15 pressure ulcers (grade 3 and 4) in July 2011 and 4 in August (until 24 August 2011).

Further work was underway with Commissioners in relation to standardising the classification and reporting of statistics, particularly in relation to pressure ulcers that developed shortly after admission and skin integrity of patients. The Associate Director of Quality, NHS LCR acknowledged the difficulty in obtaining benchmarking data and noted that in-year reduction of the Trust's pressure ulcer numbers was now being focussed on.

The Chief Executive suggested that the development of a research project to address how healthcare organisations might best reduce pressure ulcers might prove useful. Members were also advised of a forthcoming inquest in relation to pressure area care. A further report on HAPUs would be presented to the GRMC in September 2011. **MD** **DoN**

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

(B) the Director of Nursing be requested to present a report on the benchmarking information, prevention, management and reporting of HAPUs to the GRMC in September 2011, and **DoN/TA**

(C) the Medical Director (through the Director of Research and Development) be requested to consider development of a research project to address how healthcare organisations might best reduce pressure ulcers. **MD**

74/11 SAFETY AND RISK

74/11/1 Patient Safety Report

The Medical Director (on behalf of the Director of Safety and Risk) presented paper J, a summary of patient safety activity which covered the following:-

- East Midlands Quality Observatory (EMQO) information;
- patient safety week 2011;
- CAS quarterly and exception report;
- SUIs reported in July 211 at UHL, and
- UHL's 60 day performance regarding completed RCA reports.

In July 2011, the EMQO sent Acute Trusts the first edition of their quality dashboard which provided an assessment of quality across the 5 domains of the NHS Outcomes Framework. The table on Appendix 1 of the paper outlined a selection of that dashboard which covered the patient safety elements. These indicators largely demonstrated a very good patient safety performance relative to peer trusts. Members discussed this at length and particularly noted the issue in relation to day case procedures being converted to in-patients on the day. In response to a suggestion of inclusion of the observatory information within the Q&P report, it was noted that the Q&P report had more robust/up-to-date information. Responding to a further suggestion on this matter, the Medical Director advised that the CEC would focus on a process of continual review and would consider including commentary in the Q&P report within the next 3 months.

The Director of Corporate and Legal Affairs brought members' attention to section 4.3 of the report and suggested that the NPSA alert which missed the deadline for July 2011 be discussed by the QPMG in September 2011 and a further update be presented to the GRMC. **DSR**

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

(B) the Director of Safety and Risk be requested to ensure that the NPSA alert which missed the deadline for the July 2011 be discussed at the QPMG meeting in September 2011 and a further update be presented to the GRMC on 29 September 2011. **DSR/TA**

74/11/2 Risk Management Report

The Medical Director (on behalf of the Director of Safety and Risk) presented paper K, risk management report for the period 1 April - 30 June 2011, informing the Committee of UHL's key strategic risks (new reporting format), other operational risks with a risk score of 15 or above and developments within the UHL risk management arena. The Medical Director highlighted an error in section 1.2 of the report suggesting that a congruence be demonstrated between strategic risk number 13 'skill shortages' (not risk number 1 as mentioned in the paper) and operational risk relating to 'significantly reduced nurse staffing'.

Members were advised that achieving congruence between the organisational risk register and the SRR/BAF had been a complex piece of work in a relatively short period of time. Members were asked to re-assure themselves that the key strategic and organisational risks continued to be identified and reviewed to ensure that

risks/actions were being actively managed to achieve a reduced target risk score. In response to this, it was noted that some risks did not include a due date for completion - the Medical Director advised that this would be corrected in the version that would be presented to the Trust Board in September 2011.

The Medical Director also noted that Mr R Kilner, Non-Executive Director had requested 'infection prevention' risks to be included with the SRR - it was noted that a narrative to include operational failure would be included within risk 12.

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

74/11/3 Report from 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.

74/11/4 Annual Report from NIPAG

The Medical Director presented paper L, the 2010-11 annual report from NIPAG. Following review of the NIPAG terms of reference during 2010-11, it was considered that the remit of the Committee should be less 'advisory' and more an 'authorising' role. Appendix 1 detailed the terms of reference of the New Interventional Procedures Authorising Group. In 2011-12, the key priority of this group was to improve engagement with each of the CBUs to ensure that all new interventional procedures were notified to NIPAG. The Chief Executive suggested that the details of the split function of the advisory and authorising role of NIPAG be included within the 'Policy for the introduction of new interventional procedures by medical staff' at its next revision. **MD**

The NIPAG was supported by UHL's 'New Interventional Procedures' (NIP) policy which had also been reviewed and revised to reflect the new role of NIPAG and also to emphasise the necessity to provide audit and outcome data as part of the NIP process.

In response to a query from Professor D Wynford-Thomas, Non-Executive Director, it was noted that a procedure was considered 'new' if it was new to the Clinician and new to the organisation.

Responding to another query, it was noted that the 'transapical insertion of TAVI' had been temporarily discontinued until assurance in respect of the outcome of the audit relating to this procedure was provided to NIPAG.

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

(B) the Medical Director be requested to consider including details of the split function of the advisory and authorising role of NIPAG within the 'Policy for the introduction of new interventional procedures by medical staff' at its next revision. **MD**

74/11/5 Clinical Handover Process and Action Plan - Critical Safety Actions

Dr B Collett, Associate Medical Director and Ms J Ball, Divisional Head of Nursing, Planned Care attended the meeting to present papers M and N. Paper N, the action plan on the 5 critical safety actions was taken first. The Associate Medical Director provided a brief update on the objectives, lead, key actions, commencement dates, medical metrics and the reporting process for each of the critical safety actions. She advised that work was already in train for most of these actions noting that some of

these were inter-related. Divisions would need support for the robust implementation of the actions.

Ms J Wilson, Non-Executive Director noted that majority of the 5 critical safety actions were imminent and queried that once these were delivered whether new actions would be included - in response, it was noted that this had not been previously considered but it was an idea worth pursuing.

Paper M detailed the implementation of the medical and nursing handover project. An electronic handover system was being developed, however the project would start with a paper-system (in order not to further delay the project).

In response to a query on engaging medical staff in this project, it was noted that discussions had been held in some forums and specifically with CBU Medical Leads. The Director of Communications and External Relations noted the need for a programme of activity to be developed in order to have a high level engagement with clinical staff. The Associate Medical Director noted that this had currently not been done in a structured way but agreed to take forward this suggestion with support from colleagues in the Communications team. It was noted that Dr S Carr, Associate Medical Director would also pursue this further through liaison with the University. **AMD**

<u>Resolved</u> – (A) the contents of papers M and N be received and noted, and

(B) the Associate Medical Director be requested to present a structured plan for engagement in respect of the critical safety actions to ensure that the actions agreed for each of the critical safety action was cascaded to teams, as appropriate. **AMD/TA**

74/11/6 <u>Medical Metrics - Work Plan</u>

The Medical Director advised verbally that in addition to the medical metrics identified in paper N (critical safety actions) another one or two metrics would be agreed to measure and monitor aspects of medical activity and practice to improve quality, safety and efficiency of medical care.

The principle of developing the metrics would be easy measurability, uniform coverage and a potential electronic system to record the data. A definitive list of medical metrics would be presented to the GRMC in September 2011. **MD**

In response to a query on whether Clinicians would be asked to suggest ideas for the selection of the remaining two medical metrics or whether a confirmed list would be provided to them, the Medical Director advised that a hybrid approach would be taken noting that the medical metrics would reflect adherence to current policies and those associated with internal professional standards.

<u>Resolved</u> – that (A) the verbal update be received and noted, and

(B) the Medical Director be requested to present a definitive list of medical metrics to the GRMC meeting in September 2011. **MD/TA**

75/11 ITEM FOR APPROVAL

75/11/1 <u>GRMC Meeting Dates for 2012</u>

<u>Resolved</u> – that the GRMC meetings dates for 2012 (paper O refers) be approved.

76/11 ITEM FOR INFORMATION

76/11/1 Data Quality and Clinical Coding Report

Resolved – that the data quality and clinical coding report (paper P refers) be received and noted.

77/11 MINUTES FOR INFORMATION

77/11/1 Finance and Performance Committee

Resolved – that the public minutes of the Finance and Performance Committee meeting held on 28 July 2011 (paper Q refers) be received and noted.

78/11 ANY OTHER BUSINESS

78/11/1 September 2011 GRMC Meeting

The Committee Chairman advised that he had been contacted by the Director of Quality, NHS LCR requesting to schedule an item on the agenda for the GRMC meeting in September 2011 to discuss clinical risks and serious incidents. However, he noted that he had not yet received any further information.

Resolved – that the position be noted.

79/11 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 on the quality and safety monitoring of current CIP schemes (Minute 72/11/2 above refers), and**
- **discussion on the Hospital Acquired Pressure Ulcers (Minute 73/11/7 above refers)**

80/11 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 29 September 2011 from 9:30am in Conference Rooms 1A&1B, Gwendolen House, LGH site.

The meeting closed at 12:18pm.

Hina Majeed
Trust Administrator