Trust Board paper K

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 7 July 2011

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 26 May 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 2 June 2011.

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

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

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

- **discussion of Quality Account 2010-11 and Third Party Assurances (Minute 40/11/3 refers);**
- **Extended Nursing Metrics report (Minute 40/11/6 refers), and**
- **Risk Assurance Process re. 2011-12 CIPs (Minute 41/11/3 refers).**

DATE OF NEXT COMMITTEE MEETING: 30 June 2011

Mr D Tracy – Non-Executive Director and GRMC Chair
28 June 2011

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 26 MAY 2011 AT 9:00AM 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
Ms J Wilson – Non-Executive Director
Mr M Wightman – Director of Communications and External Relations

In Attendance:
Mr M Caple – Patient Adviser
Professor M Dixon-Woods – Professor of Medical Sociology, University of Leicester (for Minute 41/11/1)
Professor E Draper – Professor of Perinatal and Paediatric Epidemiology, University of Leicester (for Minute 40/11/1)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mr R Kilner – Non-Executive Director (observing)
Mrs H Majeed – Trust Administrator
Mrs C Ribbins – Director of Nursing/Deputy DIPAC
Mr I Scudamore – Consultant Obstetrician (for Minute 40/11/1)

RESOLVED ITEMS **ACTION**

35/11 APOLOGIES

Apologies for absence were received from Professor D Wynford-Thomas, Non-Executive Director.

36/11 MINUTES

In respect of Minute 27/11/1, it was noted that the job title of Mr M Parker on page 3 should read 'Associate Specialist'. It was agreed that the Trust Administrator would amend the Minutes accordingly. **TA**

Resolved – that (A) the Trust Administrator be requested to make the amendment outlined above to the Minutes of the previous meeting held on 28 April 2011; **TA**

(B) the public and private Minutes (papers A and A1 refer) of the meeting held on 28 April 2011 be confirmed as a correct record subject to the amendment above, and

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

37/11 MATTERS ARISING REPORT

The Committee Chair confirmed that the matters arising report (paper B) highlighted the matters arising from the meeting held on 28 April 2011 and provided an update on any outstanding matters arising from the GRMC meetings held since October 2009.

Resolved – that the matters arising report (paper B) and subsequent discussion on progress of a specific item be received and noted.

38/11 MATTERS ARISING

38/11/1 Development of Medical Workforce Metrics (Minute 28/11/2)

The Medical Director advised that he had discussed with the Chief Operating Officer/Chief Nurse in respect of creating meaningful metrics for the medical workforce noting that a range of medical metrics were already been recorded and reported to other Committees. He proposed that the following metrics would be reported to the GRMC from July 2011:- **COO/ CN/MD**

- use of early warning scores and response;
- VTE prophylaxis and treatment;
- compliance with Antimicrobial Prescribing policy;
- quality and timeliness of discharge letters, and
- timeliness of Emergency Department discharge and TTO letters.

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

(B) the Chief Operating Officer/Chief Nurse and the Medical Director be requested to present the first medical workforce metrics report at the GRMC meeting in July 2011. COO/ CN/MD /TA

38/11/2 Progress on Outpatient Letters (Trust Board Minute 14/11/1)

The Medical Director advised that Anglia ICE (Integrated Clinical Environment) electronic inpatient discharge letters was expected to be fully implemented by August 2011 and work was underway to develop outpatient letter templates. The roll-out of ICE outpatient letters would be done in the next few months and was expected to be completed by December 2011.

Resolved – that the verbal update be received and noted.

39/11 PATIENT EXPERIENCE

39/11/1 Quarter 4 Patient and Family Experience Report

The Director of Nursing presented paper C, an update on Caring at its Best and Patient and Family experience for quarter 4 of 2010-11. The appendices to the paper included the patient experience and care quality dashboard, 2010 patient survey report, Caring at its Best action plan and patient and family experience feedback.

The patient experience feedback activity focussed on how the Trust formally sought feedback from the public, patients and their families and the future plans to ensure feedback was gained from all patient groups at different stages of their healthcare journey. An electronic system (to be introduced through an external partner) would allow patients to be sent a feedback survey via email following their visit to the Trust which would thereby provide real time feedback.The survey response rates had increased and many more areas were using the survey to collect patient feedback. The Trust was fully compliant with same sex accommodation provision in March 2011. The privacy and dignity audits revealed that many areas had moved from ‘amber’ to ‘green’.

In addition to the Caring at its Best ten point action plan, the paper outlined the key initiatives that had been taken to improve care for patients within the Trust. An electronic system called Virtual Interactive Teaching And Learning (VITAL) had been developed which consisted of 12 modules that would assess the knowledge base of all registered nurses and midwives in relation to fundamental aspects of care – within the first three weeks of the launch of this system, 170 nurses had completed the modules. In response to a query, it was noted that there had been increased enthusiasm and motivation from staff, however, there had been challenges around IT in developing the dashboard.

Responding to a query from the Patient Adviser, the Director of Nursing advised that the Ward Sisters/Charge Nurses would be held accountable for the performance of their wards and any of their staff who had not provided the expected standards of care. Meetings had been arranged for the Chief Operating Officer/Chief Nurse and the Director of Nursing to meet with junior qualified nursing staff to discuss expectations inline with Trust's values and behaviours and provide an opportunity for staff to express any concerns. In response to a suggestion from Mr P Panchal, Non-Executive Director, the Director of Nursing agreed to include information relating to 'Equality Impact' within the cover sheet of the report.

The Director of Safety and Risk highlighted that the recent rise in complaints related to care of patients in the extra capacity wards and suggested that pro-active focus on these wards be placed in order to reduce the number of patients' complaints. It was noted that none of the wards were currently on the ward health-check. In relation to the staffing reviews summarised in page 26 of paper C, the Director of Quality, NHS LCR requested a discussion on this matter, outside the meeting. Members commented on the significant progress made to the patient experience work stream. **DoQ, NHS LCR/ DoN**

The Director of Nursing advised that a report on the National Patient Survey highlighting how the Trust was taking forward the findings within the patient experience wider work would be presented at the GRMC meeting in June 2011. **DoN**

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

(B) the Director of Quality, NHS LCR be requested to discuss nurse staffing reviews with the Director of Nursing, outside the meeting. **DoQ, NHS LCR/DoN**

(C) the Director of Nursing/Deputy DIPAC be requested to present a report on the National Patient Survey highlighting how the Trust was taking forward the findings within the patient experience wider work at the GRMC meeting in June 2011. **DoN/ TA**

40/11 QUALITY

40/11/1 <u>Perinatal Mortality – Update</u>

Mr I Scudamore, Consultant Obstetrician and Professor E Draper, Professor of Perinatal and Paediatric Epidemiology, University of Leicester attended the meeting to present paper D and a presentation on findings relating to perinatal mortality, neonatal mortality and stillbirth rates.

The following points were highlighted in particular:-

- Leicester City PCT performed poorly compared to peer PCTs in respect of perinatal mortality rates (PMR);
- Leicester County PCT PMR was equivalent to England and Wales (however, this was an affluent PCT);
- Leicester City PCT reported large proportion (70%) of <24 weeks as live births

whereas many other Trusts reported only 40%. This might be a possibility for the high figures;
- Leicester had a high rate of very pre-term (VPT) births;
- under-reporting of VPT births in some PCTs – hence there was no 'like with like' comparison, and
- large influence of preterm birth on still birth rate.

In response to a query on whether data prior to 2005 was available, it was noted that birth registration prior to 2005 did not include the gestational age. Responding to a query relating to the findings of PMR for Leicester County PCT, it was noted that this was only recently found and there were a need to look into it in further detail. Subject to approval of funding, UHL would be taking forward a bid to explore the high rate of pre-term deliveries.

It was suggested that consideration be given to visiting University Hospitals Coventry and Warwickshire and Heart of Birmingham PCT to discuss their work in relation to perinatal mortality and provide an update at the GRMC meeting in September 2011.The Committee Chairman requested for the 2010 figures to be made available. **CO/PP PE/TA**

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

(B) the Consultant Obstetrician and Professor E Draper, Professor of Perinatal and Paediatric Epidemiology be requested to consider visiting University Hospitals Coventry and Warwickshire and Heart of Birmingham PCT to discuss their work in relation to perinatal mortality and provide an update at the GRMC meeting in September 2011. **CO/PP PE/TA**

40/11/2 <u>Progress on Actions Outstanding from the Francis Inquiry Report</u>

Further to minute 3/11/1 of 27 January 2011, the Director of Clinical Quality presented paper E, an update on further progress with the three outstanding actions (improving clinical audit, impartiality of complaints and assurance against care of elderly patients) arising from the Francis Inquiry. Assurance was provided that all recommendations from the Francis Inquiry would continue to be reviewed/progressed as part of the Divisional and Corporate governance arrangements.

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

40/11/3 <u>Quality Account 2010-11 and Third Party Assurances</u>

The Director of Clinical Quality presented paper F, an update on progress with production of UHL's Quality Account and requested members' comments. The paper outlined the consultation exercise that had been undertaken. It was noted that it had been challenging to make this document 'readable' and 'accessible' due to the need for significant mandatory information to be included as laid down in the NHS QA Regulations 2010. The Director of Clinical Quality advised that the agreed quality targets and goals with our PCT were translated into a quality schedule.

The feedback from Patient Advisers had been incorporated into the document prior to circulation to stakeholders. The comments received from external stakeholders (LINks, Joint Health and Overview Scrutiny Committee and NHS LCR) had been very helpful. The Commissioners had suggested that the areas of priority for 2011-12 identified by UHL should demonstrate a commitment to improving outcomes for patients, in relation to improving patient experience, reducing admissions and further reducing deaths. In response to a query from the Medical Director, the Director of Clinical Quality advised that the QA was published on NHS Choices website but she was unaware whether it was monitored or how many people accessed the document.

The Director of Communications and External Relations emphasised that the edited highlights of the QA would be included in the Trust's Annual Report. The Chief Executive agreed to forward some minor comments to the Director of Clinical Quality, outside the meeting. The QA would be presented to the Trust Board on 2 June 2011, for approval. **CE** **DCQ**

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

(B) the Chief Executive be requested to forward comments on the Quality Account 2010-11 to the Director of Clinical Quality, outside the meeting, and **CE**

(C) the Director of Clinical Quality be requested to present the Quality Accounts to the Trust Board on 2 June 2011 for approval. **DCQ/ TA**

40/11/4 <u>Internal Audit Report on UHL CQC Processes</u>

The Director of Clinical Quality presented paper G, a report providing assurance around the ongoing monitoring of compliance with the CQC regulations within UHL. The East Midlands Internal Audit Service (EMIAS) had undertaken a review to examine the effectiveness of controls in place and this was done in accordance with the internal audit standards for the NHS. The objective of this review was to determine whether the Trust had robust corporate governance arrangements in place to support CQC compliance, whether it was embedded and if it could be demonstrated at Board and Divisional levels.

The internal auditors had provided 'significant assurance' noting that there was a generally sound system of control designed to meet the system's objectives. However, some weaknesses in the design or inconsistent application of controls had put the achievement of some particular objectives at risk. The review had identified three low risk issues, two relating to the how the Quality and Risk Profile had been used internally and one around reporting to the GRMC on action plans for CQC non-compliances. The Director of Clinical Quality advised that the recommendations had been accepted and the actions would be completed by August 2011.

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

40/11/5 <u>Clinical Audit</u>

Further to Minute 28/11/5 of 28 April 2011, the Director of Clinical Quality presented paper H, a progress report against UHL's clinical audit programme and a dashboard report for GRMC's consideration. Appendix 1 of the paper was a quarterly report on progress against the clinical audit programme (as presented to the Clinical Audit Committee in April 2011).

Appendix 3 outlined the draft UHL clinical audit dashboard and the Director of Clinical Quality requested members' comments on this template. Members commented that the template provided details of the numbers of clinical audit but did not address the qualitative aspects. Members expressed concern that the dashboard template was like a 'tick-box' exercise to provide assurance and suggested that commentary on the clinical audits would prove useful. In response, the Director of Clinical Quality advised that the details of the audits would be included within the Clinical Audit Annual Report which would be presented to the GRMC. She also agreed to present quarterly reports from the Clinical Audit Committee to the GRMC, which would detail progress on delivering the clinical audit programme. **DCQ**

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

(B) the Director of Clinical Quality be requested to schedule the Clinical Audit **DCQ/**

Annual Report and quarterly report from the Clinical Audit Committee on the agenda for the GRMC meetings, as appropriate. **TA**

40/11/6 Nursing Metrics and Extended Nursing Metrics

The Chief Operating Officer/Chief Nurse presented paper I, a summary of nursing metrics performance for April 2011, particularly noting particular progress made in the 'falls' and 'discharge' metrics. Out of the13 metrics in place, 10 scored 'green', 2 'amber' and 1 'red'. Project VITAL was in the process of being launched with a focus in the care of the elderly areas and would be rolled-out Trust wide over summer 2011.

The Director of Nursing presented paper I1, a report on the implementation of a range of nursing care metrics in the specialist areas within UHL. Responding to a query from the Committee Chairman, it was noted that metrics had now been developed for Neonatal and Children's areas and the number of areas that would be monitored would now remain the same (thereby providing consistency). The Patient Adviser complimented the Trust's improvement in the Outpatient areas with 6 indicators scoring 'green' in April 2011 (compared to 3 in March 2011). On request, the Chief Operating Officer/Chief Nurse agreed to present the extended nursing metrics to the Trust Board in July 2011. **COO/ CN**

Resolved – that (A) the contents of the nursing metrics and extended nursing metrics reports (paper I&I1 refers) be received and noted, and

(B) the Chief Operating Officer/Chief Nurse be requested to present the Extended Nursing Metrics to the Trust Board in July 2011. **COO/ CN/TA**

40/11/7 Quality and Performance Report – Month 1

The Chief Operating Officer/Chief Nurse presented papers J and J1, the quality, finance and performance report and heat map for month 1 (month ending 30 April 2011). The following points were highlighted in particular:-

- two cases of MRSA were reported for the month of April against a 2011-12 year-end trajectory of 9;
- the SHA had rejected the Trust's proposal for the 2011-12 CDiff trajectory cases and hence this would remain at 165 cases;
- slow but improving performance in relation to ED and overall waiting times noting that activity data attributed to the Urgent Care Centre (UCC) would be included within UHL's ED data;
- reduction in falls and pressure ulcers;
- the aim for UHL's mortality rate was to be in the top 25% of Trusts;
- an improvement in most of the discharge letter standards, however, performance was still below the threshold for two standards;
- the performance for 'fractured neck of femur (#NOF)' patients taken to theatre within 36 hours of attendance' was 67%, and
- improvements seen in some safety indicators.

Members further discussed the achievement of #NOF targets specifically during the capacity pressure period (i.e. bank holiday) querying whether a cost-benefit analysis needed to be taken – in response, the Medical Director agreed to inform the Chair of the #NOF Steering Group to consider proposals for improving the Trust's performance relating to care of #NOF patients (in preparation for bank holiday week-ends and winter months) and include an update on this matter within their report scheduled to be presented to the GRMC in June 2011. **MD**

In response to a query from the Committee Chairman in respect of the two MRSA cases in April 2011, it was noted that one of the cases was due to a compliance issue

but it was not attributable to only one member of staff.

Resolved – that (A) the quality and performance report and divisional heat map for month 1 (month ending 30 April 2011) (papers J and J1) be received and noted, and

(B) the Medical Director be requested to inform the Chair of the Fractured Neck of Femur (#NOF) Steering Group to consider proposals for improving the Trust's performance relating to care of #NOF patients (in preparation for bank holiday weekends and winter months) and include an update on this matter within their report scheduled to be presented to the GRMC in June 2011. **MD/TA**

41/11 SAFETY AND RISK

41/11/1 Presentation on Research relating to the Health Foundation's "Safer Patients Initiative"

Professor M Dixon-Woods, Professor of Medical Sociology, University of Leicester attended the meeting to present paper K and to provide a presentation on the evaluation of Health Foundation's Safer Patients Initiative.

Patient safety and quality of care in NHS hospitals had improved in recent years. However, the Health Foundation's Safer Patients Initiative, a large scale organisational intervention in 24 UK hospitals led by the Boston-based Institute for Health Improvement, did not appear to produce improvements over and above secular trends. Uncertainty about organisational approaches to improving patient safety remained.

Professor M Dixon-Woods advised that there were many aspects of care that were improving over the period of the study but it was likely that this was due to policy pushes and growing sophistication of hospital governance systems. Members were advised that it had been challenging to introduce such a large scale initiative. It was demanding of resource and there was a need for support from middle managers and data collection systems.

In discussion, the Director of Safety and Risk agreed to meet with Professor M Dixon-Woods, University of Leicester to discuss the quality of peri-operative care in improving the reliability of specific frontline care processes in designated clinical areas. **DSR**

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

(B) the Director of Safety and Risk be requested to arrange a meeting with Professor M Dixon-Woods, University of Leicester to discuss the quality of peri-operative care in improving the reliability of specific frontline care processes in designated clinical areas. **DSR**

41/11/2 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.

41/11/3 Risk Assurance Process re:2011-12 CIPs

The Director of Safety and Risk gave a presentation (paper L refers) providing assurance on the process for risk assessing and quality checking 2011-12 cost improvement schemes.

The following points were highlighted in particular:-

- a total of 69 CIP schemes had been identified of which 33 were recognised as having an impact on patient safety/quality of care;
- the Trust had followed Monitor's FT applicant's process for ensuring quality and safety;
- all CIP schemes had been risk assessed;
- the Trust would be undertaking confirm and challenge sessions with CBUs to pressure test their processes, and
- monitoring and reporting mechanisms were being identified;

The Director of Quality, NHS LCR sought clarity regarding the process for escalating any concerns to Commissioners – in response, it was noted that any concerns would first be reported to the Executive Team, who would then cascade it, as appropriate. Ms J Wilson, Non-Executive Director suggested that a standardised escalation process be adopted across all Divisions. **DSR**

Responding to a query from Mr P Panchal, Non-Executive Director, the Chief Operating Officer/Chief Nurse advised that all risk reviews/CIP schemes were available on a shared drive and through the Divisional confirm and challenge sessions, consideration was given to any schemes that could be aligned to other Divisions/CBUs.

The Committee Chairman suggested that the Trust's Internal and External Auditors be involved in the risk assessment process of the higher value CIP schemes – it was noted that meetings had already taken place with the Auditors regarding this matter. Further to escalation arrangements being agreed, it was suggested that this report be presented to the Trust Board and any exception reports in respect of the 2011-12 risk assurance process be provided to the GRMC. **DSR**

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

(B) the Director of Safety and Risk be requested to provide exception reports to the GRMC in relation to the risk assurance process for 2011-12 CIPs; **DSR**

(C) the Director of Safety and Risk be requested to escalate any concerns to the Executive Team regarding the process and quality tracking of CIP schemes; **DSR**

(D) further to escalation arrangements being agreed, the report on 'Ensuring Safety and Quality during the Delivery of Cost Improvement Plans' be presented to the GRMC and subsequently to the Trust Board, and **DSR**

(E) the Director of Safety and Risk be requested to present two CIP schemes, where the agreed template had been fully completed and approved to the GRMC meeting in June 2011, for assurance purposes. **DSR**

41/11/4 <u>Risk Management Report</u>

The Director of Safety and Risk presented paper M, updating the Committee on the Trust's strategic risk register/board assurance framework (SRR/BAF), organisational risks scoring 15 or above and developments within the UHL risk management processes.

The following improvements were highlighted:-

- both the strategic and organisational risk registers had become dynamic documents and CIP risks were filtering onto the risk registers;

- increased engagement at CBU level which was evidenced by the closure of risks, and
- 16 risks had a reduced risk score.

The Director of Safety and Risk expressed concern that five risks had been on the risk register for more than five years advising that three of those risks would be scrutinised and actions would be agreed at the QPMG meeting in June 2011. The risk management strategy approved by the Trust Board was now available on the Trust's document management system. The new SRR/BAF was under development, strategic risks had been identified and would be mapped to the strategic objectives. Following this, the assurance elements would be included to provide a complete SRR/BAF report at the Trust Board in July 2011. **DSR**

Members suggested the following amendments to the organisational risk register:- **DSR**

(a) page 6 – the month/year of the Finance and Performance Committee meeting to be changed in the action summary column, and
(b) page 8 – actions to be included for risk relating to 'post natal care plans'.

In discussion on the strategic risk register, it was suggested that the Medical Director gave consideration for a new strategic risk to be included within the new strategic risk register (SRR) following on from the current SRR in relation to risk 6 – 'Loss of key tertiary services'. **MD**

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

(B) the Director of Safety and Risk be requested to update the organisational risk register with the amendments suggested by members of the Committee; **DSR**

(C) the Medical Director be requested to give consideration for a new strategic risk to be included within the new strategic risk register (SRR) following on from the current SRR in relation to risk 6 – 'Loss of key tertiary services', and **MD**

(D) the Director of Safety and Risk be requested to present the new SRR/BAF at the Trust Board in July 2011. **DSR**

41/11/5 <u>Patient Safety Report</u>

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

- Executive Safety Walkabouts (ESW);
- SUI management;
- CAS exception report;
- SUIs reported in April 2011 at UHL, and
- UHL's 60 day performance regarding completed RCA reports.

ESW continued to take place many times every month to clinical areas within the Trust. Feedback from these walkabouts was sent to relevant managers for action and improvement. Currently, a new walkabout form was being designed by the Divisional Heads of Nursing to be put in context of 'Good to Great' strategy and it would be used from June 2011. In response to a suggestion from Mr R Kilner, Non-Executive Director, the Director of Safety and Risk agreed to arrange walkabouts in the outpatient areas.

The arrangements for reporting and investigation of SUIs met the required national standards. However, there was still further work to be done to evidence that the Trust was embedding the learning from incidents and investigations in order to improve

patient outcomes, safety and experience. In discussion on assurance in relation to learning and improving from SUIs, it was suggested that a thematic review of SUIs should be shared with the Divisions via the QPMG and the outcome of this be reported to the GRMC. **DSR**

Responding to a query from Mr P Panchal, Non-Executive Director, it was noted that it would be challenging to set-up a central system to track all SUIs, however, the Director of Safety and Risk agreed to include the number of SUIs month on month within future Patient Safety reports. **DSR**

Members queried whether there was a consistent method to monitor SUIs across all Divisions and suggested that Internal Audit undertook a follow-up exercise on action plans arising from the investigation of a couple of serious untoward incidents. **DSR**

Section 4 of the paper outlined that there were no missed alert deadlines in regard to CAS alerts in April 2011.

A total of 24 SUIs were escalated during the month of April 2011 (6 related to patient safety incidents, 15 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3 and 4) and 3 related to healthcare associated infections).

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

(B) the Director of Safety and Risk be requested to ensure that a thematic review of SUIs be discussed by the QPMG and the outcome of this discussion be reported to a future meeting of the GRMC, as appropriate; **DSR/ TA**

(C) the Director of Safety and Risk be requested to include the number of SUIs month on month within future Patient Safety reports, and **DSR**

(D) the Director of Safety and Risk be requested to ensure that Internal Audit undertake a follow-up exercise on action plans arising from the investigation of a couple of serious untoward incidents. **DSR**

41/11/6 <u>Standardised Handover</u>

The Director of Safety and Risk advised verbally that analysis of incidents had indicated some failings relating to medical and nursing handovers. Improving clinical handovers had been identified as a key safety action for 2011-12. Work in relation to standardising medical handover was led by Dr B Collett, Associate Medical Director and nursing handover was led by Ms J Ball, Divisional Head of Nursing, Planned Care.

The minimum standards for nursing handover was being piloted in two wards in the Planned Care Division and it would be rolled-out in the others wards of this Division over the summer months and then throughout the Trust.

In respect of the medical handover, particular issues had been highlighted in the night handover. Plans were in place to undertake handover sessions at 9:00pm from 1 July 2011 initially at the LRI site which would be led by the Critical Care Outreach team, junior doctors, specialist registrars and night manager in order to:-

- identify critically ill or deteriorating patients;
- ensure test results were actioned, and
- prompt for senior clinical review.

The Director of Safety and Risk suggested that the Associate Medical Director and the Divisional Head of Nursing, Planned Care be invited to attend a future GRMC meeting **DSR**

to provide an update on the handover process.

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

(B) the Director of Safety and Risk be requested to arrange for the Associate Medical Director and the Divisional Head of Nursing, Planned Care to attend a future GRMC meeting to provide an update on the handover process. **DSR/ TA**

42/11 ITEMS FOR INFORMATION

42/11/1 Quarterly report from the Clinical Effectiveness Committee (CEC)

Resolved – that the quarterly report from the CEC (paper O refers) be received and noted.

42/11/2 CQC's Review of Compliance – LGH and St Mary's Birth Centre

Resolved – that the report on CQC's review of compliance against the essential standards of quality and safety at the LGH site (paper P refers) and St Mary's Birth Centre (paper P1 refers) be received and noted.

42/11/3 Data Quality and Clinical Coding Report

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

42/11/4 Six Lives Action Plan – Update

Resolved – that the update on Six Lives action plan (paper R refers) be received and noted.

42/11/5 Vetting and Barring Scheme

Resolved – that the update on the Vetting and Barring scheme (paper S refers) be received and noted.

42/11/6 **Corporate Nursing and Operations Directorate Performance**

Resolved – that the Corporate Nursing and Operations Directorate performance (paper T refers) be received and noted.

43/11 MINUTES FOR INFORMATION

43/11/1 Finance and Performance Committee

Resolved – that the public and private minutes of the Finance and Performance Committee meeting held on 27 April 2011 (paper U) be received and noted.

43/11/2 Clinical Effectiveness Committee

Resolved – that the minutes of the Clinical Effectiveness Committee meeting held on 4 March 2011 (paper V) be received and noted.

44/11 ANY OTHER BUSINESS

44/11/1 Coroner's Inquest

The Director of Communications and External Relation brought members' attention to

a Coroner's inquest relating to a case of missed diagnosis in 2005.

Resolved – that the verbal update be noted.

45/11 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 of Quality Account 2010-11 and Third Party Assurances (Minute 40/11/3 refers);**
- **Extended Nursing Metrics report (Minute 40/11/6 refers), and**
- **Risk Assurance Process re. 2011-12 CIPs (Minute 41/11/3 refers).**

46/11 DATE OF NEXT MEETING

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

The meeting closed at 12:20pm.

Hina Majeed
Trust Administrator