Trust Board Paper K

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: 2 February 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy, Non-Executive Director

DATE OF COMMITTEE MEETING: 4 January 2012. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 5 January 2012.

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:

- **Summary of five critical safety actions (Minute 04/12/1 b refers);**
- **Discussion on the 10Xmedication errors in children (within the patient safety report) (Minute 04/12/2 refers), and**
- **Update on the ward 16 fire (Minute 07/12/1 refers).**

DATE OF NEXT COMMITTEE MEETING: 26 January 2012.

Mr D Tracy, Committee Chairman
27 January 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON WEDNESDAY 4 JANUARY 2012 AT 1PM 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
Mr M Lowe-Lauri – Chief Executive
Mrs E Rowbotham – Director of Quality, NHS LCR (non voting member)
Mr S Ward – Director of Corporate and Legal Affairs
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Dr S Campbell – Divisional Director, Clinical Support (for Minute 04/12/1a)
Dr B Collett – Associate Medical Director, Clinical Effectiveness
Mrs H Majeed – Trust Administrator
Ms A Randle – Senior Safety Manager (Clinical Risk and Complaints)
Dr A Rashid – Medical Director, NHSLCR

ACTION

RESOLVED ITEMS

01/12 APOLOGIES

Apologies for absence were received from Miss M Durbridge, Director of Safety and Risk; Mrs S Hinchliffe, Chief Operating Officer/Chief Nurse; Mrs S Hotson, Director of Clinical Quality; Mr P Panchal, Non-Executive Director; Mrs C Ribbins, Director of Nursing/Deputy DIPAC and Mr M Wightman, Director of Communications and External Relations.

02/12 MINUTES AND ACTION SHEET

Resolved – that the Minutes and action sheet (papers A-A2) from the meeting held on 25 November 2011 be confirmed as a correct record.

03/12 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.

Resolved – that the matters arising report (paper B) be received and noted.

03/12/1 Women's and Children's Complaints Performance Report – Analysis of complaints data in the context of local demographics

Resolved – that this item be deferred to the GRMC meeting on 26 January 2012. **DCER**

04/12 SAFETY AND RISK

04/12/1a Update on one Critical Safety Action – Acting Upon Results

Dr S Campbell, Divisional Director, Clinical Support attended the meeting to present an update on the critical safety action relating to 'Acting upon Results'. She advised that within UHL, 3 different systems (1 paper system and 2 electronic systems) were used to request patients' tests and record results. The electronic iCM system had been fully rolled out, however due to certain challenging experiences usage currently stood at around

70%. This system did not have an audit facility to measure whether a result had been acted upon or not. The Sunquest ICE system was a GP ordering system. The mobility of patients and junior doctors across the hospital was also a factor which complicated the test results to be actioned. The Medical Director noted the need for a system which provided electronic ordering of tests and also electronic acknowledgement of results.

The Divisional Director, Clinical Support proposed that the paper system should be abandoned and the ICE system should be rolled out across the organisation as it had an audit facility. It was noted that IM&T Directorate were developing a project plan and assessing the costs involved. Further to the project plan being approved, it would take approximately 3-4 months for it to be rolled out which would involve implementation, education and training. The ICE system would be piloted in the Emergency Department setting and in some clinical areas in January 2012. The Committee Chairman requested that the Executive Team agree which system should be implemented in order to ensure that 'Acting Upon Results' was appropriately delivered. The Divisional Director, Clinical Support was requested to present an options appraisal report to the Executive Team in late January 2012 regarding a move to an electronic system to allow audit of reading of test results. Responding to a query, it was noted that there was little consistency in terms of which system was used by other Trusts. The Medical Director, NHS LCR strongly suggested the need to move to one electronic system rather than having parallel systems in place. **DD,CS**

UHL's Medical Director requested that an electronic system for ordering patients tests for inpatients be mandated with immediate effect – the Divisional Director, Clinical Support agreed to take this forward. **DD,CS**

<u>Resolved</u> – that (A) the Divisional Director, Clinical Support be requested to present an options appraisal report to the Executive Team in late January 2012 regarding a move to an electronic system to allow an audit of reading of test results, and **DD, CS/TA**

(B) the Divisional Director, Clinical Support be requested to ensure that an electronic system for ordering patients tests for inpatients was put into effect on an immediate basis. **DD,CS**

04/12/1b <u>Summary of all 5 Critical Safety Actions and Monitoring Arrangements</u>

The Associate Medical Director presented paper C, an update on the 5 critical safety actions and the progress made so far. The critical safety actions work was receiving increasing exposure and was beginning to penetrate into CBU cultures and actions. Appendix A of the paper provided the project overview and monitoring arrangements.

The Associate Medical Director provided a brief update on each of the critical safety actions as follows:-

<u>Improving Clinical Handover (Appendix B refers):</u>- Members were advised that two systems (doctor to doctor handover and nurse to nurse handover) were in place. These were electronic web-based systems which were updated depending on the bed-state. The doctor to doctor handover system had been piloted in the Medicine CBU on 23 December 2011. Results would be audited to ascertain how often it was used and whether any extra elements had been highlighted which would not have been possible through the normal handover process. The new system would alert medical staff to patients who were acutely unwell, patients requiring action and patients with high early warning scores. Consultant Champions had been identified and a meeting had been arranged to discuss the ways they could support and encourage the use of the new system. The new system would be rolled out at the Leicester Royal Infirmary in the beginning of April 2012 and to the other two sites by the end of April 2012.

The training for the nurse to nurse handover system was being done by the Divisional Heads of Nursing to Matrons who would further cascade it to their respective teams.

The Committee Chairman queried the difference the new system would make once implemented – in response, it was noted that the system provided an audit facility to understand whether handover took place, the patients that were discussed, the actions agreed and the time taken to complete the actions. Professor D Wynford-Thomas, Non-Executive Director queried whether the standardisation of the handover process improved the quality of the handover (i.e. whether it would prompt staff to include information that they did not record when they used the paper system) – it was noted that the new system would only pick-up information that was inputted, however, having a standardised process was vital for improving efficiency, patient safety and patient experience.

Responding to a query, it was noted that resource had not yet been identified for a project manager to support the implementation of the project and undertake audits. The Medical Director, NHS LCR agreed to check progress in relation to the bid from transitional funds to support implementation of 5 critical safety actions. The Associate Medical Director agreed to present the preliminary audit data of the system which was piloted in the Medicine CBU at the GRMC meeting on 26 January 2012. **AMD**

Relentless Attention to Early Warning Score (EWS) Triggers and Actions (Appendix C refers):- This was a nationally recognised safety action which all nurses were aware of and increasing focus was now placed on junior doctors' responsibility to review the patient on a timely basis and escalate to a senior appropriately where needed. Junior doctors had been made aware that non-response (to requests to review a patient's rising EWS) would be escalated to Consultant-level. The VITAL training package for nurses provided information relating to EWS usage and escalation process. The handover template also allowed the recording of EWS. The EWS response time had been altered and the expected time of response was required to be stated on EWS charts – awareness of this was being reinforced across the Trust. The work of Ms C Barclay, Outreach Sister in promoting the RSVP tool was recognised and it was noted that patients with EWS of greater than 6 were required to be reported to the Outreach team.

In response to a query from Ms J Wilson, Non-Executive Director, it was noted that the Divisional Boards were discussing the learning from SUIs relating to EWS, however there needed to be an improvement in ways of informing clinical areas in this respect. The Senior Safety Manager advised that UHL's new 'Learning from Experience' Group (with membership from all Divisions) would be a platform to share lessons learned from incidents.

Responding to a query, the Associate Medical Director agreed to confirm the timescale for all nurses to have completed the training of the VITAL programme. The Committee Chairman noted that work was in progress and considered that the systematic implementation of the handover system would assist in the recording of EWS. **AMD**

Mortality and Morbidity (M&M) Action Plan (Appendix D refers):- the Medical Director advised that standardised templates for reviewing in-hospital deaths and morbidity had been developed and circulated for CBUs to use at their M&M meetings. There was a delay in setting a central repository to record minutes of M&M meetings, however Divisions had been advised to record this on a shared drive. The M&M meetings in most specialities were held on a monthly basis and by exception for a few specialties (i.e. Ophthalmology). The M&M processes would be monitored through the Clinical Effectiveness Committee.

Ms J Wilson, Non-Executive Director noted that all unexpected in-hospital deaths would be reviewed within 3 months and queried the reason for this lengthy timescale – the Medical Director advised that this timescale had been agreed due to practicality issues in tracking the case notes of the patients in order to undertake the review. It was suggested that a smaller timescale be agreed by default and the 3 month timescale for exceptional cases would seem appropriate. The Medical Director agreed to consider the timescale for reviewing all unexpected in-hospital deaths and alter the wording of the objective under **MD**

the 'Mortality and Morbidity' action plan.

Acting Upon Results (Appendix E refers):- had been covered within Minute 04/12/1a.

Senior Clinical Review, Ward Rounds and Notation (Appendix F refers):- This critical safety action had arisen due to the different ways of working in terms of ward rounds. A Consultant group had been established in order to develop a standard type of format and a meeting had been scheduled to be held at the end of January 2012. In response to a query, it was noted that one of the reasons for SUIs was that issues had not been escalated to senior decision makers. The Medical Director, NHS LCR noted that this was a vital critical safety action and suggested that priority be given to this. In relation to any resources required to progress this safety action, he advised that the bid for transitional funds for 2012-13 could be put forward from April 2012.

In discussion on the development of key performance indicators (KPIs) for this critical safety action, the Chief Executive suggested that this be discussed with the Brookfield Group and consider whether it was an area for potential joint development. It was suggested that the Associate Medical Director (Clinical Education) be invited to attend the GRMC meeting on 26 January 2012 to provide a further update on this safety action. **CE** **AMD (Cl. Ed.)**

In respect of the KPIs for all critical safety actions, the Associate Medical Director and the Director of Safety and Risk would discuss how to ensure that progress and improvements were tracked and reported appropriately. The KPIs for critical safety actions used in other Trusts would be explored. Responding to a query, it was noted that an application for a project manager to support implementation of the critical safety action project had been put forward through a bid from transitional funds. An application from the Deanery was being sought to support a part-time medical lead post in respect of the medical aspects of this project. **AMD**

In conclusion, the Committee Chairman suggested that the commentary on critical safety actions be included within monthly quality and performance reports.

The Committee Chairman also requested that the 5 critical safety actions be considered as follows when SUIs were investigated:-

(a) what happened at handover;
(b) whether attention was given to EWS and if appropriate escalation was followed;
(c) was the death discussed at a M&M meeting;
(d) was there a delay in acting on results, and
(e) did the patient receive senior clinical review and was documentation robust.

He suggested that brief details of the above be included within the SUI information section of future iterations of the Patient Safety reports to the GRMC. It was agreed that the implementation of the five critical safety actions would be presented to the Executive Team on 24 January 2012. **DSR** **AMD**

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

(B) an audit of the electronic handover system piloted in the Medicine CBU be undertaken, with an update accordingly to the 26 January 2012 GRMC; **AMD/TA**

(C) the timescale for all nurses to have completed the training of the VITAL programme be confirmed outside the meeting; **AMD**

(D) the 5 critical safety actions be considered when investigating each Serious Untoward Investigation and brief details of this be recorded within the SUI information section of future iterations of the Patient Safety reports to the GRMC; **DSR/ SSM**

(E) the timescale for reviewing all unexpected in-hospital deaths be reconsidered, **MD**

and amended accordingly in the 'Mortality and Morbidity' action plan;

(F) the key performance indicators for the critical safety action relating to 'Senior Clinical Review, Ward Rounds and Notation' be discussed with the Brookfield Group, as an area for potential joint development; **CE**

(G) the KPIs for critical safety actions used in other Trusts be explored; **AMD**

(H) implementation of the five critical safety actions be presented to the Executive Team on 24 January 2012, and **AMD/MD**

(I) the Associate Medical Director (Clinical Education) be invited to attend the GRMC meeting on 26 January 2012 to present an update on progress in relation to the Critical Safety action on 'Senior Clinical Review, Ward Rounds and Notation'. **AMD(Cl. Ed.)/TA**

04/12/2 Patient Safety Report – SUI Data

The Senior Safety Manager introduced the Patient Safety Report (paper D refers) which included SUIs reported in November 2011, the CAS exception report, 60 day RCA performance and the NHS Midlands and East draft policy for the reporting and management of serious incidents in the East Midlands.

A total of 18 SUIs had been escalated during November 2011 (8 related to patient safety incidents, 7 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3&4) and 3 related to Healthcare Acquired Infections). The Medical Director had met with the Divisional Director, Women's and Children's and the Chief Pharmacist to discuss the SUIs relating to 10X medication errors in that Division. He advised that there was no technical reason for not including the paediatrics service within the EPA software, however, resource needed to be identified to extend the system to include a children's formulary. It was noted that the Great Ormond Street Hospitals had published this formulary. The Committee Chairman requested that a report on 10X medication errors in children with comparative data from other Trusts be provided at the GRMC meeting on 26 January 2012. The Chief Executive agreed to check with the Brookfield Group whether benchmarking information for 10X medication errors in children was available. **MD** **CE**

Professor D Wynford-Thomas, Non-Executive Director queried whether the investigation process of SUI 21383 had brought to light the reason for the cause of the error, in response, it was noted that the main reason for 10X medication errors was due to pharmacists/nurses working in a pressurised environment. Discussions had been held with Professor S Petersen, University of Leicester to develop an educational training video to prevent medication errors. Paediatrics nurses were also now required to take a numeracy test.

In discussion on a SUI relating to the care of a deteriorating patient, it was noted that the initial review of the medical and nursing records had made it apparent that the deterioration had been acted upon in a timely manner.

Responding to a query from the Patient Adviser in respect of SUI 21308, the Medical Director provided a brief update of the incident and it was noted that this was now in-hand.

In relation to the 60 day RCA performance, members' were advised that 7 SUIs had exceeded the 60 day limit and this was due to a variety of reasons.

The most significant changes in relation to the recent revised NHS Midlands and East policy for reporting and management of serious incidents were:-

(a) the absolute requirement for grade 1 RCA level 2 investigations to be completed and provided to the Lead Commissioner within 45 working days of the incident being reported (change from the current 60 working days), and

(b) investigations would need to be conducted by staff not involved in the incident, locality or Directorate/Division in which it occurred, be overseen by a Director level Chair or facilitator and involve patient/relative/carer input as appropriate.

In discussion on point (a) above and although noting the challenging nature of this timescale, members commented that it would be beneficial to complete investigation reports within 45 working days as any learning/lessons could be implemented more rapidly than at present. Commissioners were aware of the Trust's concerns and the Medical Director, NHS LCR advised that they might consider extensions on an exceptional basis, however. The Associate Medical Director voiced concerns that undertaking point (b) would prove challenging. The Senior Safety Manager noted the need for investigation teams with appropriate skill mix to be developed, which would be further discussed at the QPMG meeting on 11 January 2012. **DSR**

In discussion on appendix 1 (CAS Alerts), it was requested that assurances around outstanding CAS alerts and likely dates for closure be included within the 'comment' column of future iterations of this paper. **SSM**

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

(B) a report on 10X medication errors in children (with comparative data from other Trusts) be presented to the 26 January 2012 GRMC; **MD**

(C) a view be sought from the Brookfield Group as to whether benchmarking information for 10X medication errors in children was available; **CE**

(D) a report be provided to the 11 January 2012 QPMG in respect of the implications of the NHS Midlands and East draft policy for the reporting and management of serious incidents in the East Midlands, and **DSR/TA**

(E) assurances around outstanding CAS alerts and likely dates for closure be included within the 'Comment' column of future iterations of the paper. **SSM**

04/12/3 <u>Complaints Action Update</u>

It was noted that the Medical Director, Chief Operating Officer/Chief Nurse, Director of Communications and External Relations, Director of Safety and Risk and Senior Safety Manager had met to brainstorm ideas on how to deal with complaints.

A meeting with the Heads of Nursing and Quality Teams in the Medicine CBU and GI Medicine/Surgery/Urology CBU with representation from the patient experience team and a Patient Adviser had been held on 3 January 2012. The Senior Safety Manager advised that the following agreed actions were being taken forward by those CBUs:-

(a) to arrange meet and greet services in clinics;
(b) to arrange provision of drinks for patients waiting significant lengths of time in clinics;
(c) the patient experience team to explore re-introduction of visible/manned areas within hospital entrances where patients could obtain information and advice;
(d) to co-ordinate specific training for front line staff to help them deal with patient concerns, and
(e) to identify a designated point of contact between Patient Information and Liaison Service and Divisions to ensure a prompt response to queries.

The Patient Adviser also noted that complaints management at external organisations was being explored. He would be working with the Quality and Safety Manager, Planned Care Division to explore ways to reduce complaints being re-opened. A further meeting had been planned to share Divisional and Corporate actions and an update report would be provided to the GRMC in March 2012. **SSM**

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

(B) an update on complaints management be provided to the 29 March 2012 GRMC. **SSM/TA**

04/12/4 Service Improvement Project Manager – Teenage and Young Adults Service – Recruitment Plans

Resolved – that this item be deferred to the GRMC meeting on 26 January 2012. **COO/CN/ TA**

04/12/5 Safeguarding Case Reviews

Resolved – it be noted that there were no cases to report.

05/12 QUALITY

05/12/1 Nursing Metrics and Extended Nursing Metrics

The Medical Director, NHS LCR noted the need to triangulate the nursing metrics results with the patient survey – in response, the Committee Chairman advised that this was already being undertaken through the ward health-checks.

Resolved – that the contents of papers E and E1 be received and noted.

05/12/2 Quality, Finance and Performance Report – Month 8

In the absence of the Chief Operating Officer/Chief Nurse, it was suggested that the detail of the month 8 quality, finance and performance report be discussed at the Trust Board meeting on 5 January 2012. **COO/CN**

Resolved – that (A) the quality and performance report and divisional heat map for month 8 (month ending 30 November 2011) be discussed at the Trust Board meeting on 5 January 2012; **COO/CN/ TA**

(B) the update in respect of the actions taken to reduce the number of operations cancelled on or after the day of surgery be deferred to the GRMC meeting on 26 January 2012, and **COO/CN/ TA**

(C) an update on discussion with the Head of Outcomes and Effectiveness regarding the additional assurance through enhanced monitoring of patient mortality rates between ED and Medicine CBUs be deferred to the GRMC meeting on 26 January 2012. **COO/CN/ TA**

05/12/3 Improving UHL's Summary Hospital Mortality Index (SHMI) Performance – change plans/timescales

The Medical Director provided a verbal update advising that in relation to UHL's 'higher than expected' SHMI value, a review of a sample of case notes of deceased patients in three of the top ten diagnosis groups – 'Urinary Tract Infection', 'Myocardial Infarction' and 'Gastro-intestinal Bleed' had been undertaken. The purpose of the review had been to confirm whether the diagnosis had been correctly coded and also the depth of coding in respect of co-morbidities. The findings from the review indicated that there was a consistent lack of clarity regarding the patients' probable and confirmed diagnosis. Members were also advised that co-morbidities had not been clearly documented. Further to these findings, work had been initiated by the Coding team to support improvement of clinical coding. Work was also underway with public health colleagues in relation to 'out of hospital deaths'.

Resolved – that the verbal update be noted.

05/12/4 Medical Metrics

The Associate Medical Director, Clinical Effectiveness reported verbally advising that she had contacted Professor A Darzi and other colleagues in Imperial College London in relation to medical metrics – a response was still awaited. Contact had also been made with a colleague in Cleveland clinic and a response was awaited. The Associate Medical Director agreed to discuss this further with the Head of Outcomes and Effectiveness and the Clinical Audit Manager and provide an update in February 2012. **AMD**

Resolved – that the Associate Medical Director be requested to provide an update on the development of appropriate medical metrics at the GRMC meeting in February 2012. **AMD/TA**

06/12 MINUTES FOR INFORMATION

06/12/1 Finance and Performance Committee

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

07/12 ANY OTHER BUSINESS

07/12/1 Ward 16 – Fire

The Senior Safety Manager provided a verbal update on the Ward 16 fire at the Glenfield Hospital on 25 December 2011 and highlighted the following in particular:-

(a) the apparent cause of the fire;
(b) that the whole of ward 16 had been evacuated within 14 minutes, with all patients moved to wards 32 and 33a;
(c) there were no patient injuries;
(d) three members of staff were being treated for smoke inhalation, and
(e) the police had attended and there were no charges to be brought as there was 'no intent' and it was not in the public interest to pursue.

The Chief Executive noted the need for a robust investigation process to be undertaken and a report be presented to the GRMC on 26 January 2012. The sensitivity of smoke alarms/sprinkler systems should also be considered. **DSR**

Resolved – that an investigation report re: the Glenfield Ward 16 fire be presented to the 26 January 2012 GRMC, with appropriate consideration also given to the sensitivity of smoke alarms/sprinkler systems. **DSR/TA**

07/12/2 WHO Checklist

The Medical Director, NHS LCR emphasised the need for 100% compliance with the WHO surgical safety checklist. **MD**

MD

Resolved – that the Medical Director be requested to ensure that the WHO surgical safety checklist was appropriately implemented.

07/12/3 Appraisals

The Medical Director, NHS LCR noted that the appraisal figures in the Acute Care Division were rated 'amber' and requested that this be appropriately managed, noting also the level of SUIs within Acute Care compared to other UHL Divisions.

Resolved – that the Medical Director be requested to raise the above with the Acute Care, Division for appropriate action. **MD**

08/12 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 2 February 2012 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

- **summary of five critical safety actions (Minute 04/12/1 b refers);**
- **discussion on the 10Xmedication errors in children (within the patient safety report) (Minute 04/12/2 refers), and**
- **update on the ward 16 fire (Minute 07/12/1 refers)**

09/12 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 26 January 2012 from 1:00pm in the Cedar Room, Knighton Street Offices, Ground Floor, Glenfield Hospital.

The meeting closed at 3.15pm

Hina Majeed,
Trust Administrator