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: 25 OCTOBER 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Ms J Wilson (Acting Chair)

DATE OF COMMITTEE MEETING: 24 September 2012

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

- None

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

- None

DATE OF NEXT COMMITTEE MEETING: 22 October 2012

Ms J Wilson
19 October 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON MONDAY 24 SEPTEMBER 2012 AT 2:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Ms J Wilson – Non-Executive Director (Acting Chair)
Mr M Caple – Patient Adviser (non voting member)
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Nurse/Deputy Chief Executive
Ms C Trevithick – Chief Nurse and Quality Lead, West Leicestershire CCG (non voting member)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations
Professor D Wynford-Thomas – Non-Executive Director and Dean of the University of Leicester Medical School.

In Attendance:
Mr J Braybrooke – Consultant Orthopaedic Surgeon (for Minute 98/12/1)
Dr S Campbell – Divisional Director, Clinical Support (for Minute 98/12/2)
Ms N Grant – Lead Nurse, Musculoskeletal CBU (for Minute 98/12/1)
Ms M Harris – Divisional Manager, Acute Care (for Minutes 98/12/3 and 98/12/4)
Mrs S Hotson – Director of Clinical Quality
Mrs S Khalid – Chief Pharmacist (for Minute 98/12/4)
Miss B Kotecha – Assistant Director of Learning and Organisational Development (for Minute 98/12/4)
Mr A Lane – Deloitte Representative (observing)
Ms S Mason – Divisional Head of Nursing, Acute Care (for Minutes 98/12/3 and 98/12/4)
Mrs C Ribbins – Director of Nursing

RESOLVED ITEMS **ACTION**

96/12 APOLOGIES

Apologies for absence were received from Mr J Birrell, Chief Executive; Mr D Briggs, Chair, East Leicestershire & Rutland CCG (non voting member); Dr B Collett, Associate Medical Director; Miss M Durbridge, Director of Safety and Risk; Mr P Panchal, Non-Executive Director and Mr D Tracy, Non-Executive Director.

97/12 MINUTES

Resolved – that the Minutes of the meeting held on 20 August 2012 be confirmed as a correct record.

98/12 MATTERS ARISING REPORT

The matters arising report at paper B highlighted both issues from the most recent GRMC meeting and provided an update on any outstanding matters arising since September 2011. Members noted in particular:-

- Minute 88/12/1a – the Divisional Director, Clinical Support to present a report on the Clinical Support Division's actions to support the reduction of Emergency Theatre Waiting Times at the GRMC meeting in November 2012; **DD, CSD**
- Minute 88/12/1b – a report on clinical audit and benchmarking information (National Joint Registry) be presented to the GRMC in November 2012, and **MD/DCQ**
- Minute 66/12a – the Director of Corporate and Legal Affairs to confirm whether the inquest date re: SUI (STEIS reference 2011/3518) was available and an update on actions (following a recent review of the action plan) be scheduled on the GRMC agenda before December 2012, as **DCLA**

appropriate.

Resolved – that the matters arising report and the actions above, be noted. **DD,CSD/MD /DCQ/DCLA**

98/12/1 Fractured Neck of Femur (#NOF) Performance

Further to Minute 66/12/1 of 25 June 2012, Mr J Braybrooke, Consultant Orthopaedic Surgeon and Ms N Grant, Lead Nurse, MSK CBU attended the meeting to present paper C, an update on performance in relation to the #NOF Best Practice Tariff and CQUIN indicators. Members noted that the performance for #NOF patients taken to theatre within 36 hours of attendance had deteriorated in July 2012 due to multifactorial reasons, however early indications for August 2012 showed an improvement to this position.

The dedicated ward for #NOF patients was in place at the end of June 2012. Patient flow in this ward had been an issue during July 2012 due to the number of admissions which had resulted in transferring post #NOF patients to another trauma ward.

Responding to a query from the Chief Nurse and Quality Lead, West Leicestershire CCG, the Consultant Orthopaedic Surgeon commented that he expected the additional trauma theatre sessions which were now in place would suffice to cope with winter pressures. The Director of Clinical Quality requested the 'RAG' rating in paper C to be updated. Members were advised that the feedback from the patient surveys had been very positive and the Director of Nursing requested the CBU representatives to ensure that patients responded to the surveys.

In response to a query, the Chief Nurse/Deputy Chief Executive agreed to confirm to the Lead Nurse, MSK CBU whether the transformation bids for the Orthogeriatrician PAs had been approved. **CN/DCE**

The Acting Chair thanked the MSK representatives for attending the GRMC meeting on a quarterly basis to provide updates on #NOF performance. She suggested that GRMC would continue to monitor improvements in fractured neck of femur performance through the Quality and Performance report and any concerns would be escalated appropriately.

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

(B) the Chief Nurse/Deputy Chief Executive to confirm to the Lead Nurse, MSK CBU whether the transformation bids for the Orthogeriatrician PAs had been approved. **CN/DCE**

98/12/2 Cost Improvement Programme 2012-13 – Assurance re: Quality and Safety Standards

The Divisional Director, Clinical Support attended to provide an update on the Clinical Support Divisional CIP schemes and ongoing process regarding quality impact assessments, KPIs, monitoring and actions to mitigate risk. She advised that CIP schemes were RAG rated on a weekly basis as part of the Divisional metrics meeting and any issues affecting clinical quality were flagged. CIPs were also on the agenda for the monthly CBU meetings and the Divisional Board received the minutes of the CBU meetings. In response to a query, it was noted that the CBU Clinical Leads were responsible for CIPs, however the overall accountability was with the Divisional Director.

Resolved – that the verbal update be noted.

98/12/3 Acute Care Divisional Risk Register

The Divisional Manager and Head of Nursing, Acute Care attended the meeting to present paper D, an update on current risks which were above the risk score of '12' on the Acute Care divisional risk register. Processes were now in place to improve position and embed the risk registers into everyday practice. The Acute Care Divisional Board was informed of the risk register via the quality and safety reports on a monthly basis and the CBUs were asked to discuss risks at the Board meeting. The Quality and Performance Management Group reviewed divisional risk registers on a monthly basis and the Trust Board received quarterly exception reports.

In response to a query from the Patient Adviser, it was noted that refurbishment of Odames ward on the LRI site was being considered in order to make it fit for purpose. Responding to queries, it was noted that the risk in respect of 'high risk patients for haemodialysis' related to patients who had been abroad.

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

98/12/4 Progress with action plans re:CQC visit to the LRI site – 27 and 28 June 2012

Further to Minute 89/12/7 of 20 August 2012, the Director of Clinical Quality presented paper E. She advised that action plans for outcome 9 (medicines management) and outcome 14 (support of staff) had been drafted and would be monitored by the Medicines Management Group and Workforce and Organisational Development Committee respectively. Appendix 6 provided a position statement against the warning notice and actions taken to ensure compliance.

Mrs S Khalid, Chief Pharmacist attended to provide an update on outcome 9 (appendix 3 refers). The action plans for outcome 9 had been submitted to the CQC and was monitored fortnightly by the Executive Team. She advised that weekly audits were being undertaken and feedback on position was provided to the respective areas. There had been an improvement to the weekly audits but a full compliance position had not yet been reached. A brief update on the areas that were non-compliant was provided. She noted the need for exceptional arrangements for urgent access to drug fridges within high risk emergency areas and a pragmatic approach needed to be developed so that safety was not compromised. The Chief Nurse/Deputy Chief Executive confirmed that letters had been sent to staff reminding them of the consequences of non-compliance and the performance management measures in place to address this.

In respect of CQC's finding in relation to 'patients own medicines were found with their personal belongings' – it was noted that medicines of patients arriving in the Theatres Arrival Area were now put in green bags, however a more sophisticated approach was being sought. The weekly audits would be undertaken until a continuous compliance position was reached.

Ms M Harris, Divisional Manager, Ms S Mason, Divisional Head of Nursing and Miss B Kotecha, Assistant Director of Learning and Organisational Development presented an update on outcome 14 (appendix 4 refers). In respect of the local actions taken in the Acute Care Division, members noted that weekly Emergency Department meetings had been arranged which were attended by representatives from all disciplines (clinical & non clinical). A monthly newsletter was now developed which was a means of communication and information sharing and also encouraged feedback from staff. Internal audits would take place during September 2012 (led by Divisional Manager for Acute Care) for assessing improvement in communication and feedback to the team. The Director of Human Resources would be updated on the outcome of the audit and the outcome 14 compliance action plan would be amended accordingly to reflect any further improvements required. Responding to a query from the Medical Director, it was noted that

anonymous audits would be undertaken.

The Acting Chair requested that an update on the above be provided to the GRMC meeting in October 2012. **CP/ DCQ/ DM,AC**

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

(B) on behalf of the Chief Pharmacist, the Director of Clinical Quality to provide a verbal update on progress with outcome 9 (medicines management), and **CP/DCQ**

(C) the Divisional Manager, Acute Care to attend the October 2012 GRMC meeting to provide an update on progress with outcome 14 (support of staff). **DM,AC**

99/12 QUALITY

99/12/1 Nursing Metrics and Extended Nursing Metrics

Further to Minute 89/12/1 of 20 August 2012, paper F provided a simplified interim summary of nursing dashboard information and a further update would be presented to the GRMC in October 2012.

Areas which did not achieve improvements against 5 or more metrics were highlighted for alternate weekly review and ward manager remedial plans. Further to the August 2012 GRMC meeting, clinical notes that were used a part of the NHSLA officers visit had been reviewed by the Corporate Nursing team with a particular focus on the nursing metrics. The results were found to be consistent with those undertaken on a monthly basis giving confidence that the monthly metric results provided an accurate picture of measurement in this area.

There had been significant improvement to the 'resuscitation' indicator with the position moving from 77% in July 2012 to 83% in August 2012. Performance management measures were in place for non-compliance with this particular indicator. The increase of almost 4 points (57.6) to the Net Promoter score from July 2012 represented the largest single improvement in score since the baseline of 51 in April 2012.

There had been an incremental reduction of grade 2, 3 and 4 pressure ulcers. The number of pressure ulcers was reported as part of the Safety Thermometer with the baseline taken from March 2012. However, it was specifically noted that the safety thermometer data was being taken mid-month, therefore the final data position might differ to that reported via the CQUIN where end of month validated data was reported.

Responding to a discussion on falls assessment, the Chief Nurse/Deputy Chief Executive advised that a detailed review of falls would be presented to the October 2012 meeting and she agreed to include an update on the relationship between the falls assessment process and outcomes. **CN/DCE**

Members raised queries on the wards that had been RAG rated as 'red' – in discussion on this issue, it was agreed that the revised format of the nursing metrics paper should include commentary on the steps being taken to improve performance in these ward areas. **CN/DCE**

In response to a query from Ms J Wilson, Non-Executive Director, it was noted that the nursing metrics had now been displayed on wards.

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

(B) the Chief Nurse/Deputy Chief Executive to present a detailed review of falls which included an update on the relationship between the falls assessment process and outcomes, and **CN/DCE**

(C) the revised format of the nursing metrics paper to include commentary on the steps being taken to improve performance in wards which had been RAG rated 'red'. **CN/DCE**

99/12/2 Month 5 Quality, Finance and Performance Report

Papers G and G1 comprised the quality, finance and performance report, heat map and associated management commentary for month 5 (month ending 31 August 2012). Reflecting the GRMC's focus on quality, risk and patient safety aspects, the Chief Nurse/Deputy Chief Executive highlighted the following issues by exception:-

(a) the Trust's Internal Auditors had been requested to undertake a review of the imaging waiting lists – this review was expected to be completed by end of September 2012;
(b) the percentage of operations cancelled on/after the day of admission of all elective activity for non-clinical reasons had seen a significant improvement with the position moving to 0.5% against a target of 0.8%, and
(c) the 62 day urgent referral to treatment cancer target for July 2012 was 85.5% against a target of 85%. Responding to a query on the actions in place to sustain performance of this target – it was noted that additional Clinicians were in place, however there were still some capacity gaps. The Chief Nurse/Deputy Chief Executive agreed to provide updates on key topics on a rotational basis to the GRMC. **CN/DCE**

The Medical Director highlighted that the following indicators were rated 'green':-
(a) Mortality rates;
(b) 5 Critical Safety Actions;
(c) UHL Quality Schedule/CQUIN;
(d) Fractured Neck of Femur 'Time to Theatre', and
(e) VTE Risk Assessment.

The 'Readmissions' indicator remained 'amber' and in further discussion on the independent readmissions audit led by the Leicester University, it was agreed that the findings would be presented at the October 2012 GRMC meeting. **MD**

Resolved – that (A) the contents of papers G and G1 be received and noted;

(B) the Chief Nurse/Deputy Chief Executive to provide update on key issues to the GRMC on a rotational basis, as appropriate, and **CN/DCE**

(C) the Medical Director to present the audit findings from the 'independent' readmissions audit led by the University of Leicester. **MD**

99/12/3 Quarterly Update on Hospital Acquired Pressure Ulcers

Paper H provided evidence to confirm that the Trust continued to make progress in reducing the incidence of avoidable hospital acquired pressure ulcers and was now focusing on elimination as opposed to reduction. The report also provided an update on the implementation of the NHS Safety Thermometer in UHL. Work continued to support the SHA ambition across the organisation to ensure that all actions from the Intensive Support Team (IST) review of pressure ulcers were achieved.

The Director of Nursing advised that the SHA had identified the safety thermometer as the most effective measuring system that they would use to monitor progress

with the ambition, although it had been acknowledged that the tool cannot differentiate between avoidable and unavoidable ulcers. However, the SHA have confirmed that based on the assumption that 5% of ulcers were unavoidable if all patient care solutions were in place, a monthly trajectory for each organisation had been set with the aim of eliminating 95% of the baseline pressure ulcers by December 2012.

The report provided an overview of the operational and strategic leadership for SHA's ambition across the local healthcare community and outlined the provision of SHA education and training initiatives that would support the sustainability of the ambition within organisations through cultural and behavioural change.

Members noted that Dr R May, Nurse Director, NHS Midlands and East would be visiting the Trust on 3 October 2012 and this subject would be further discussed with her.

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

99/12/4 SHA Dashboard

Reporting verbally, the Chief Nurse/Deputy Chief Executive highlighted the following in particular in respect of the SHA dashboard:-

- the 46 hospitals cited within the dashboard formed part of the Midlands and East SHA footprint. The position of Trusts was calculated by affording a ranking to a suite of performance indicators (i.e. 1 – 46), and then ranking the sum totals to result in a performance table (i.e. the higher the score the lower performer);
- where there was no data available, the trust did not receive a ranking value;
- where services are not applicable (i.e. ED in 4 trusts), no ranking value was given (all these trusts were in the top 10);
- 1 breach of a mixed sex accommodation would rank a Trust in the mid 30's;
- where targets are being met, ranking could also be low;
- not all Trusts provide cancer services. For this group, a first position ranking was afforded for that indicator;
- one Trust only provided a service for 2 week cancer waits and is overall ranked as 1st in cancer waiting times, and
- ranking or performance was not based on size or complexity. The bed base ranged from 114 to 1653 (UHL). The top 6 ranked Trusts had less than 300 beds.

The Director of Communications and External Relations and the Chief Nurse/Deputy Chief Executive discussed how to make best use of the data from comparable Trusts in the dashboard. In response to a suggestion from the Medical Director, the Chief Nurse and Quality Lead, West Leicestershire CCG agreed to contact the SHA to get an understanding of their views/proposals/framework in respect of the long term plan of the SHA dashboard and provide an update to the GRMC in October 2012. **CN&QL, WL CCG**

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

(B) Chief Nurse and Quality Lead, West Leicestershire CCG to contact the SHA to get an understanding of their views/proposals/framework in respect of the long term plan of the SHA dashboard and provide an update to the GRMC in October 2012. **CN&QL, WL CCG**

99/12/5 CQC Quarterly Self Assessment

Paper I summarised the quarter 2 internal self assessments with the 16 quality and

safety CQC outcomes. The internal self assessment provided a high level review and covered the whole Trust whilst the CQC visits provided an in-depth review of a particular clinical area/service subject. The Director of Clinical Quality advised that her team were considering better ways of undertaking the self assessments.

The Acting Committee Chair noted the need for Divisions to take ownership – in response, it was noted that it was intended that Divisions would take ownership prior to the next quarterly self assessment which was due at the end of October 2012. The Director of Corporate and Legal Affairs commented that Divisional accountability for completing actions which had been planned to move to a compliance position in respect of the internal self assessments had been discussed at a recent Executive Team Time Out session and noted that this would be re-inforced further at future ET meetings.

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

99/12/6 Quarterly CQUIN Reconciliation

Paper J summarised performance against the quarter 1 thresholds for Quality Schedule (QS) and CQUIN indicators. Performance was reviewed by the Clinical Quality Review Group and East Midlands Specialised Commissioning Group (EMSCG). Two of the QS indicators were RAG rated 'red' and one was rated 'amber'. Thresholds for the LLR CQUINs had been fully achieved with the exception of the 'ED/EMAS handover' which was rated 'amber'. Further data for this indicator had subsequently been submitted with a request for review of the rating. In respect of the EMSCG CQUINs, thresholds were fully achieved for all but one of the schemes (performance status recording prior to IV Chemotherapy) which was rated 'amber'. Further data had been submitted which now showed an improved position than originally stated.

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

100/12 SAFETY AND RISK

100/12/1 Patient Safety Report

In introducing the monthly update on patient safety issues (paper K), the Medical Director (on behalf of the Director of Safety and Risk) noted the following matters by exception:-

(a) the never events thematic review – in discussion on this report, the Medical Director stressed that lessons had been learned from the cases reviewed. A task and finish group had been established and appropriate work streams developed. The Acting Chair suggested that an update on these work streams be provided to the GRMC in November 2012 noting that this would be monitored through the QPMG; **DSR**
(b) assurance that actions put in place following external report into the Trust's 2003 treatment of a specific patient had been completed;
(c) potential changes to the NHSLA scheme were provided for information;
(d) an update on the August 2012 SUIs, 1 related to a patient safety incident, 14 related to the reporting of HAPUs. The Medical Director specifically highlighted that the never event summarised in the report might not have happened if electronic prescribing was in place and stressed the importance of driving forward the implementation of EPMA within all areas in the Trust.

The Acting Chair queried about the new SHA serious incident policy – in response, the Medical Director noted the need for discussions with Commissioners in respect of this policy in order to get a clear interpretation on the requirements. He agreed to

circulate a summary of the revised East Midlands SHA "Policy for the Reporting and Management of Serious Incidents in the East Midlands" to GRMC members, for information. The Chief Nurse/Deputy Chief Executive also agreed to ensure that a discussion was raised with Dr R May, Nurse Director, NHS Midlands and East in respect of the reporting and investigation requirements in respect of this new policy and a verbal update be provided to the GRMC in October 2012. **MD** **CN/DCE**

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

(B) an update on the work streams developed following the thematic review of never events be provided to the GRMC in November 2012; **DSR/TA**

(C) the revised East Midlands SHA "Policy for the Reporting and Management of Serious Incidents in the East Midlands" be discussed with Dr R May, Nurse Director, NHS Midlands and East in respect of the reporting and investigation requirements and a verbal update be provided to the GRMC in October 2012, and **CN/DCE**

(D) a summary of the new SHA incident policy be circulated to GRMC members, for information. **MD**

100/12/2 Winter Planning

The Chief Nurse/Deputy Chief Executive reported verbally that a meeting with Divisional representatives had been held to discuss any lessons learned from 2011 winter planning exercise. The following were highlighted in particular:-

(a) discussions were on-going with the Interim Chief Executive in respect of increased focus on LLR system working and patient flows;
(b) plans to provide additional 'step down' capacity using one of the wards at the LGH site;
(c) Divisions to identify any additional inpatient space (e.g. 4 bed bays currently utilised for non clinical functions), and
(d) consideration being given to refurbishment of Odames ward.

A joint presentation on winter planning in the presence of UHL and CCG colleagues would be made at the Trust Board in October 2012. Advice was being sought from the HPA in relation to seasonal flu. The Acting Chair and the Patient Adviser commented that they had recently visited the Odames ward and there was positive feedback from staff inspite of the infrastructural challenges in this area.

Resolved – that the verbal update be received and noted.

100/12/3 Annual Report from NIPAG

Paper L provided a summary of work undertaken by the New Interventional Procedures Authorising Group in 2011-12 and areas of focus for 2012-13.

Resolved – that paper L be received and noted.

100/12/4 Report by the Director of Nursing

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.

101/12 PATIENT EXPERIENCE

101/12 Quarterly Patient Experience Report

/1

The Director of Nursing introduced paper M, which provided an update on the patient and family feedback for quarter one (April-June 2012). An average of 1700 surveys was returned each month from 85 areas/wards. In addition, surveys were completed through the electronic route, comments were received through free text section in the survey, message to matrons cards were received with compliments/ suggestions and comments were also received through NHS Choices and Patient Opinions website. She advised that the role of the patient experience team was to collect patient feedback inline with national and local expectations. However, it was highlighted that the majority of improvements in response with patient feedback could only be achieved by the clinical teams led by the Divisions. The Corporate Patient Experience team had 2.2 WTE staff who engaged in facilitating the collection of feedback and work streams to improve services and care

The Divisions had formulated action plans for 2012-13 in response to patient feedback. These action plans would provide direction and structure allowing the Divisions to deliver on improving experience outcomes for patients within their specialties. The report also provided an update on the action plan devised to improve services for carers following the Carers engagement event held in December 2011.

Responding to a query from the Patient Adviser in respect of a suggestion from patients relating to 'better food', the Director of Nursing advised that as the comments on food were subjective, it was a challenging area to resolve, however these issues were reported and actioned through the Food Forum. The Acting Chair also noted the need to reflect on the context of staff attitude issues.

<u>Resolved</u> – that paper M be received and noted.

101/12 <u>Patient Experience Feedback Priorities</u>
/2

Paper N provided an overview of the patient experience feedback priorities for 2012-13 including the four Divisional action plans to improve the experience of care for patients. During 2011-12, four Divisional 'Caring at its Best' projects were initiated in response to patient feedback within the Trust and were the vehicle for improvements in patient experience. The progress against these project plans had been reported to the Quality and Performance Management Group (QPMG) with the achievement of milestones monitored.

The Director of Nursing emphasised that there were recurrent themes drawn from Divisional action plans that provided the following Trust level overarching framework/ priorities for 2012/13:

- patients, family and carers feel informed and are given options;
- improved efficiency processes for patients;
- improved care for people at end of life;
- improve the care for patients with dementia, and
- improve the care for older people.

In response to a concern from the Patient Adviser, the Chief Nurse/Deputy Chief Executive agreed to ensure that Divisions were reminded about the need to include patient experience in the monthly CBU reports, inline with the guidance provided as a part of the governance pack. **CN/DCE**

The Director of Communications and External Relations expressed disappointment that the report did not include smart objectives and timescales for actions to be completed. In response, the Director of Nursing advised that the detailed Divisional action plans were presented and monitored by the QPMG. In further discussion on **DN**

this item, she agreed to present the Trust-level overarching framework of the patient experience priorities for 2012-13 to the GRMC in October 2012.

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

(B) the Trust-level overarching framework of the patient experience priorities for 2012-13 be presented to the GRMC in October 2012, and **DN/TA**

(B) the Chief Nurse/Deputy Chief Executive to ensure that Divisions were reminded about the need to include patient experience in the monthly CBU reports, inline with the guidance provided as a part of the governance pack. **CN/DCE**

101/12/3 <u>Caring at its Best – Improving Patient Experience in Clinical Practice</u>

The Director of Nursing provided an overview of the practice development trial which was devised to support Clinical Divisions in responding to feedback and improving experience for patients (paper O refers). This framework/trial was called 'Caring at its Best – Improving Patient Experience in Clinical Practice'.

The Haematology ward embarked on this trial in September 2011 which focused on specific areas where the ward scored 'red' in local and national patient surveys. The programme involved observing staff interaction with patients and each other along with interviewing patients about identified areas. A brief update on this was provided. Evidence suggested that by raising staff awareness in patient experience could dramatically improve patient experience results. Over a 12 month period, survey results showed a significant increase in all areas previously identified as 'red'. The patient experience team lead on a large number of Trust wide initiatives, however the current resource within the team did not allow this programme to be delivered to the whole Trust with the intensity and pace required.

Professor D Wynford-Thomas, Non-Executive Director noted that the trial commenced in September 2011, however most of the changes to practice where in place only in summer 2012 and queried the reason for this – in response, it was noted that it was not a quick process as it involved interactions with staff and patients and then required analysis of the evidence collected. Responding to a further query, the Director of Nursing highlighted that the key to the success of this programme was consistency and sustainability of taking forward the actions and effective leadership to embed it within teams.

The Director of Corporate and Legal Affairs welcomed this trial noting that the key attribute for the improvement in results was because staff had taken ownership and noted that this needed to be linked with the Trust's Organisational Development plan – in response, the Director of Nursing acknowledged this and noted that the Assistant Director of Learning and Organisational Development was kept informed about this methodology.

In discussion on the need for additional clinical staff in the Patient Experience Team to take forward this programme across the Trust, the Chief Nurse/Deputy Chief Executive agreed to give consideration as part of budget setting at the end of November 2012. An update on progress and plans for this programme would to be included in the Quarter 2 Patient and Family Experience Feedback Report. **CN/DCE** **DN**

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

(B) the Chief Nurse/Deputy Chief Executive to give consideration for additional clinical staff in the Patient Experience Team to take forward the above programme across the Trust, and **CN/DCE**

(C) an update on progress and plans for Caring at its Best – Improving Patient

Experience in Clinical Practice programme be included in the Quarter 2 Patient and Family Experience Feedback Report. **DN**

102/12 ITEM FOR APPROVAL

102/12/1 GRMC Meeting Dates for 2013

Resolved – that the schedule of GRMC meeting dates for 2013 (paper P refers) be confirmed as:-
Monday, 21 January
Monday, 18 February
Monday, 18 March
Monday, 22 April
Monday, 20 May
Monday, 17 June
Monday, 15 July
Monday, 19 August
Monday, 16 September
Monday, 21 October
Monday, 18 November
Monday, 16 December

103/12 MINUTES FOR INFORMATION

103/12/1 Finance and Performance Committee

Resolved – that the Minutes of the 25 July 2012 Finance and Performance Committee meeting (paper Q refers) be noted for information.

104/12 ANY OTHER BUSINESS

There were no items of any other business.

105/12 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that the Acting Chair to highlight specific items to the 27 September 2012 Trust Board. **Acting Chair**

106/12 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Monday, 22 October 2012 from 12:30pm in the Board Room, Victoria Building, Leicester Royal Infirmary. **TA**

The meeting closed at 5:07pm

Cumulative Record of Members' Attendance (2012-13 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Tracy (Chair)	6	5	83%	C Trevithick*	5	4	80%
J Birrell	3	0	0%	S Ward	6	4	66%
D Briggs*	6	2	33%	M Wightman	6	3	50%
M Caple*	6	4	66%	J Wilson	6	4	66%
K Harris	6	5	83%	D Wynford-Thomas	6	4	66%
S Hinchliffe	6	5	83%				
P Panchal	6	3	50%				

* non-voting members
Hina Majeed, **Trust Administrator**