Trust Board Paper J

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: 26 April 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 29 March 2012. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 5 April 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:

- **Planned Care Division – Complaints Performance (Minute 33/12/1a refers);**
- **Complaints Management (Minute 33/12/1 c refers) ;**
- **Draft Annual Operational Plan 2012-13 (Minute 34/12/5a refers), and**
- **CIPs 2012-13 Safety and Quality Assurance Process (Minute 34/12/5b refers).**

DATE OF NEXT COMMITTEE MEETING: 21 May 2012

Mr D Tracy
16 April 2012

DRAFT

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 29 MARCH 2012 AT 1PM IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Dr K Harris – Medical Director
Mr M Lowe-Lauri – Chief Executive (up to and including Minute 36/12/2)
Mr P Panchal – Non-Executive Director
Mrs E Rowbotham – Director of Quality, NHS LCR (non voting member)
Mr M Wightman – Director of Communications and External Relations

In Attendance:
Ms J Ball – Head of Nursing, Planned Care (for Minutes 33/12/1, 34/12/6b and 36/12/5a)
Dr H Brooks – Consultant Anaesthetist (for Minute 33/12/2)
Miss M Durbridge – Director of Safety and Risk
Mr A Furlong – Divisional Director, Planned Care (for Minutes 33/12/1, 34/12/6b and 36/12/5a)
Mrs S Hotson – Director of Clinical Quality
Mr N Kee – Divisional Manager, Planned Care (for Minutes 33/12/1, 34/12/2, 34/12/6b and 36/12/5a)
Mrs H Majeed – Trust Administrator
Ms A Randle – Senior Safety Manager (for Minutes 33/12/1, 34/12/6b and 36/12/5a)
Mrs C Ribbins – Director of Nursing/Deputy DIPAC
Ms E Ryan – Head of Nursing, Clinical Support/ Acting CBU Manager, Theatres (for Minute 33/12/2)
Ms M Wain – Quality, Safety and Risk Manager, Planned Care (for Minutes 33/12/1, 34/12/6b and 36/12/5a)

ACTION

RESOLVED ITEMS

31/12 APOLOGIES

Apologies for absence were received from Mr M Caple, Patient Adviser (non voting member), Dr B Collett, Associate Medical Director, Clinical Effectiveness, Mrs S Hinchliffe, Chief Operating Officer/Chief Nurse, Mr S Ward, Director of Corporate and Legal Affairs, Ms J Wilson, Non-Executive Director and Professor D Wynford-Thomas, Dean of the University of Leicester Medical School and Non-Executive Director.

32/12 MINUTES

Resolved – that the Minutes (papers A-A1) from the meeting held on 23 February 2012 be confirmed as a correct record.

33/12 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.

33/12/1 Complaints Update

a. Planned Care Division – Complaints Performance Report

The Divisional Director, Head of Nursing and the Quality and Safety Manager, Planned

Care attended the meeting to present paper C, an update on the complaints activity for the first three quarters of 2011-12 and to demonstrate the actions being taken to respond to complaints received by the Division.

The Divisional Director, Planned Care advised that though there had been an increase in the total number of complaints in 2011-12 in comparison with 2010-11, there had not been a marked increase in complaints when set against the increase in patient activity. The complaint themes were mostly in relation to waiting times, cancellations and appointments. From April 2011 – January 2012, the Division achieved 97% for complaints responded to in 25 days and 100% for complaints responded to in 10 days.

Section 5 of paper C highlighted the on-going work streams to reduce the number of concerns and complaints received across all specialties within the Planned Care Division. The Divisional Head of Nursing particularly drew members' attention to the following:-

- 10 point plan actions were regularly discussed with the Ward Sisters, Matrons and the Head of Nursing, and
- a programme of ward rounds with all qualified nurses in the Division focussing on patient experience and emphasis on Trust values had commenced.

The process for responding to complaints had been reviewed and adjusted and a telephone call was made to each complainant to seek to resolve the issue verbally, if appropriate, or to arrange a meeting ahead of a formal written response.

b. Complaints Benchmarking Data

In response to a comment from the Divisional Director, Planned Care in respect of the challenges to obtain formal benchmarking data for complaints, the Chief Executive advised that he had commenced discussions with the Brookfield Group with a view to obtaining such data and would provide an update to the GRMC, when available. **CE**

c. Complaints Management

Paper D provided a brief update on the actions taken by the Complaints Improvement Task Group. As the actions from the Acute Care Division were not available at the time of writing the report, the Senior Safety Manager provided a verbal update highlighting the following:-

- training sessions had been arranged for Matrons and Lead Nurses to empower them to give the skills to deal with complainants;
- a process was now in place to resolve issues upfront, and
- posters had been displayed in ward areas to encourage patients/visitors to raise any concerns as they arose.

In response to a query, members were advised that medical staff had not been included in the membership of the Complaints Improvement Task Group due to the timing of the meeting, however discussions/actions from the meeting were fed back to them.

The Senior Safety Manager briefed the Committee on a new complaints handling process to capture patients' concerns, these were not allocated as formal complaints unless explicitly stated. However, the concern would be escalated as a complaint, if the patient still remained unsatisfied with the response and actions taken to resolve the issues raised. The figures for the number of complaints in 2010-11 and 2011-12 was provided noting that there had been an increase but actions were in place to address this.

The Medical Director expressed concern advising that further work on analysing the complaint themes was required specifically noting that 'waiting times' and 'cancellations' were the main reasons for the rise in complaints. In response, the Divisional Director,

Planned Care advised that the Division had made significant progress in clearing the backlog, however, the resolution of issues in relation to emergency flows and time taken for diagnostic procedures would further assist in reducing the waiting times. The Chief Executive commented on the scope to change processes.

The Director of Nursing reported that the patient experience survey responses suggested a low level of satisfaction from patients in Ophthalmology and ENT specialities and queried whether any actions had been taken to resolve the issues. The Divisional Director, Planned Care advised that the reason for issues in the Ophthalmology specialty were due to ward moves which had led to a number of cancellations. However, this had led to initiatives for delivering the service differently and the proposal was to establish a day case suite with four inpatient beds. This proposal was due to be presented to the next Site Reconfiguration Board meeting. The Chief Executive strongly supported this proposal and welcomed a discussion with the Divisional Director, Planned Care outside the meeting. In relation to the ENT specialty, it was noted that the delays in pathways would be considered through the Lean service improvement approach. **CE/DD, PC**

In response to a comment from Mr P Panchal, Non-Executive Director on the process to manage cancellations and whether a standardised approach was in place, members discussed a personal approach by a senior member of staff to in-patients in the event that their operation was cancelled on the day of surgery.

Responding to a query from the Director of Safety and Risk, members of the Planned Care Division advised that their Division had re-designed the complaints handling process and were committed to reduce the number of complaints. However, they were uncertain whether this would lead to a reduction in 10% of complaints received by the Division, noting that some complaints received by their Division were not directly related to concerns in the Planned Care Division. In response, the Director of Safety and Risk advised that the number of complaints received by the Planned Care Division was higher than other Divisions and suggested that the complaints be escalated if it seemed that they were not due to issues specifically relating to Planned Care.

The Chief Executive noted the need for predicted modelling. Mr P Panchal, Non-Executive Director noted the low level of complaints in the Cancer, Haematology and Oncology CBU and queried whether this was due to the excellent service provided or due to patients being reluctant to complain. The Quality and Safety Manager advised that this CBU had a different clinical setting and patients built a good rapport with the staff due to long-term nature of their treatment. Responding to a query, the Director of Nursing advised that she had attended one of the Divisional meetings and reported that good practice was shared by the CBUs and healthy competition was also noted. The Learning from Experience Group maximised the potential for sharing, learning and improving the quality and safety of patient services.

In conclusion, the Committee Chairman suggested that the Acute Care Division be invited to attend the GRMC meeting in July 2012 to present the complaints performance data for quarter 1 of 2012-13 to indicate whether there had been a reduction in complaints, noting the target improvement set of 10% reduction in formal written complaints received. **ACD**

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

(B) an update on complaints benchmarking data following discussion with the Brookfield Group be provided to a future meeting of the GRMC, when available; **CE**

(C) the Chief Executive and the Divisional Director, Planned Care be requested to discuss outside the meeting in respect of taking forward the establishment of a day case suite for the Ophthalmology service, and **CE/DD, PC**

(D) the Acute Care Division be requested to attend the GRMC meeting in July 2012 **ACD/TA**

to present the complaints performance data for quarter 1 of 2012-13 to indicate whether there had been a reduction in complaints, noting the target improvement set of 10% reduction in formal written complaints received.

33/12/2 Update on Theatre Modernisation Programme

Ms E Ryan, Acting CBU Manager, Theatres and Dr H Brooks, Consultant Anaesthetist attended the meeting to present paper E, an update on the theatre transformation project.

Responding to a query in relation to compliance with the WHO checklist, it was noted that all elective and maternity theatres complied with the checklist, however due to time constraints in respect of operating on patients in an emergency, the main elements of the checklist were completed. The Director of Quality, NHS LCR reported that a recent visit by the GP Commissioner and a CCG Lead indicated that they were impressed with the work undertaken in respect of WHO checklist compliance specifically in elective care and noted the work on-going in emergency care. Members were advised that from April 2012, a monthly audit of the WHO checklist would be implemented in each theatre using ORMIS (theatre systems).

In response to a comment by the Medical Director, it was noted that meetings had been set up between theatres and each CBU to review activity, utilisation and cancellations. Lists were actively managed and unused sessions were reallocated to other specialties. Theatre staff including Anaesthetists were transferred across sites to support other areas to reduce the risk of cancellations.

Members were advised that sickness absence remained a concern within the Theatres CBU and had risen since the additional RTT activity, however was being actively managed. Members noted that staff were working hard and noted the need for a good working environment. The Acting Theatres CBU Manager advised that refurbishment of theatres and essential maintenance work was underway and a refurbishment plan was being prepared. The Committee Chairman suggested that an update on progress with the theatres refurbishment business case be provided to the GRMC in June 2012. **ACM, Theatres**

In 2012-13, the Chief Executive noted the need for early proposals to be drawn so that any additional RTT activity was completed within quarter 3 so as not to increase staff workload. There was a need for assertive management of lists starting and running on time and reductions to the overall cost to the organisation by reducing theatre cancellations.

The Committee Chairman noted that the theatre transformation project aimed at reducing the number of theatres to 36 from its current 46 and queried how this would be taken forward. In response, the Acting Theatres CBU Manager advised that work was underway to achieve this and proposed the following options to take this forward:-

- the whole organisation to move to a 7 day working week;
- increase operating sessions from 3.5 hours to 4 hours in all specialties which would improve theatre utilisation;
- relocate day case activity to the Community, and
- improve utilisation of all the Trusts operating sessions to above 86% (which was identified as national best practice).

She advised that a meeting had been scheduled on 26 April 2012 for all CBUs to meet and discuss the potential activity for 2012-13 and the time required for theatre sessions. The merger of under-utilised sessions and improving theatre utilisation to support the theatre closure programme would also be discussed at this meeting.

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

(B) the Acting Theatres CBU Manager be requested to provide an update on progress with the theatres refurbishment business case to the GRMC in June 2012. **ACM, Theatres /TA**

34/12 QUALITY

34/12/1 Nursing Metrics and Extended Nursing Metrics

Paper F summarised progress against the nursing metrics for the period August 2009 - February 2012. Out of the 13 metrics in place, 10 scored 'green' and 3 'amber'. In February 2012, marginal reductions had been noted across mainstream metric areas. Whilst seasonality and current emergency pressures might be a factor, key areas would have a subsequent mid-month review to assess levels of reduction. Paper F1 detailed the extended nursing metrics in place within 8 specialist areas across the Trust. Responding to a query, it was noted that weekly metrics had been undertaken for the extra capacity wards and improvements had been evidenced. The Director of Quality, NHS LCR commented that the PCT were impressed by the nurse leadership which had been identified from observational visits to extra capacity wards. Further to a lengthy discussion on the extra capacity wards, it was suggested that these wards should be included within the metrics as soon as they were opened. **DoN/ COO/CN**

Resolved – that (A) the contents of papers F and F1 be received and noted, and

(B) the extra capacity wards be included on the nursing metrics as soon as such wards were opened. **DoN/ COO/CN**

34/12/2 Quality, Finance and Performance Report – Month 11

Papers G and G1 detailed the quality, finance and performance report, heat map and associated management commentary for month 11 (month ending 29 February 2012). The Director of Nursing highlighted that the patient polling data for extra capacity wards was captured but was reported as figures of the ward that the patients originally came from. The Director of Quality, NHS LCR noted that the majority of fracture neck of femur (#NOF) 'time to theatre' breaches were due to patients not being fit for theatre. She also noted that an audit on the reasons for delays had identified a need for additional routine theatre capacity in order to cope with the increased demand and the impact of spinal admissions on theatre slots. She suggested that the dynamics of closing theatres (Minute 33/12/2 above refers) be appropriately considered. The Medical Director advised that an update on #NOF performance had already been scheduled for the GRMC meeting in April 2012.

Members were advised that no cases of MRSA were reported during February 2012 with a year to date position of 7. Although there had been an increase in the number of pressure ulcers from December 2011, overall incidence continued to reduce when comparing data from January 2011. For the last eleven months, all UHL wards and intensivist areas continued to offer same sex accommodation (SSA) in line with the UHL SSA matrix guidance.

The Medical Director advised that the VTE risk assessment performance had been maintained and the national CQUIN threshold of 90% had been met both in January and February 2012. In respect of readmissions, agreement had been made with Commissioners on a holding threshold (20%) for the penalisation of readmissions for 2012-13.

Resolved – that the quality and performance report and divisional heat map for month 11 (month ending February 2012) be noted.

34/12/3 2011-12 Quality Account (QA)

The Director of Clinical Quality presented paper H, a draft version of the 2011-12 QA for sign-off by the GRMC prior to external circulation to stakeholders with the final draft being presented to the Trust Board in June 2012. She advised that the QA had been discussed by the Executive Team at its meeting on 6 March 2012 and it had been agreed that the three priorities from 2010-11 should be continued for 2011-12 as these had not been fully achieved. In addition to the three main priorities for improvement, other specific areas for improvement had also been identified which had been listed in section 3.5 of paper H. **DCQ**

It was suggested that on page 37, the number of MRSA bacteraemias be confirmed prior to inclusion of the figure. The Director of Clinical Quality advised that the details of the recent CQC visits would also be included.

Resolved – that (A) the draft quality account be signed-off, subject to the inclusion of the above comments, and

(B) the final draft of the Quality Account be presented to the Trust Board in June 2012. **DCQ**

34/12/4 EMQO Acute Quality Dashboard

The Medical Director presented paper I, a report on the quality dashboard developed by 'The Midlands and East Quality Observatory' (EMQO) for Acute Trusts in the East of England and East Midlands, comparing performance at a national level. This dashboard included indicators from various sources providing an indication of quality across the 5 domains of the NHS outcomes framework. The EMQO had advised that the aim of the dashboard was to stimulate questioning and investigation, share learning and enable service improvement. The Clinical Effectiveness Committee had agreed that CBUs would incorporate relevant Acute Trust Quality Dashboard indicators into their own specialty dashboards in order to monitor performance on an ongoing basis. The specialty dashboard would then be populated via the data warehouse, on a monthly basis (where available) and overarching indicators would be incorporated into the UHL Quality and Performance report. GRMC members supported this proposed approach.

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

(B) the proposed approach for ongoing review and monitoring of indicators included in the Midlands and East Acute Trust Quality dashboard be supported.

34/12/5 Annual Operational Plan 2012-13

a. Final Draft

The Chief Executive advised that the 2012-13 Annual Operational Plan was still a draft version and it was proposed that it would not be presented to the Trust Board on 30 March 2012, for sign-off. The financial section of the plan had not yet been concluded as there was a need to relate it to the CIP programme and transformation requirements. The delivery of emergency care performance, 62 day cancer targets, supply of middle grade doctors were the areas that required further review. The Committee Chairman noted that the safety, quality and patient experience aspects of the AOP were not sufficiently robust and welcomed an opportunity to provide input into these sections prior to the Trust Board's consideration of the AOP on 5 April 2012. The Director of Communications and External Relations acknowledged this and reported that he had worked with the Director of Strategy and the latest version of the executive summary now provided an appropriate narrative. The Director of Safety and Risk noted the need for some data (i.e. falls) to be updated. **Chair**

Resolved – that the Committee Chairman be requested to contact the Director of Communications and External Relations and the Director of Strategy with any input **Chair**

into the AOP before Trust Board's consideration on 5 April 2012.

b. CIPs 2012-13 Safety and Quality Assurance Process

Paper K provided an update on the current CIP management processes. A process had been set up to ensure that sufficient challenge and scrutiny was applied to all identified CIP schemes to ensure that they delivered the savings identified in year without having any unmitigated risks. As well as reviewing CIP templates submitted by CBUs, the Transformation Support Office would meet all CBUs on a fortnightly basis. All CIPs would be assessed to check that:-

- these were operationally deliverable and achievable;
- the financial benefit and phasing of that benefit was based around reasonable assumptions;
- risks had been indentified and appropriate mitigation strategies had been put in place and had been signed off by the Divisions/Corporate Directors, and
- they delivered genuine Trust savings and did not simply move cost around within the Trust.

It was noted that an initial review had indicated that 154 CIP schemes had been identified. CBUs were required to undertake a full risk assessment if schemes had a value of (£65k or more) or schemes which had a risk score of (12 or more). For these schemes, a quality assurance proforma was also required to be completed. The Committee Chairman requested that a sample of these proformas for schemes with a value of >65k be circulated to the GRMC, for information. **DSR**

The Director of Quality, NHS LCR requested that updated risk assessments for 2012-13 CIPs be forwarded to her. **DSR**

The Director of Safety and Risk noted the need for consideration to be given to how the accumulation of risks was captured and assessed and how risks identified in one Division impacted on quality in another. A variety of views were expressed in respect of the CIP confirm and challenge process with CBUs and members agreed that each Division be invited to attend a monthly GRMC meeting to present the CIP proformas and ongoing process regarding quality impact assessments, KPIs, monitoring and actions to mitigate risks. **DSR**

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

(B) the updated risk assessments for 2012-13 CIPS be circulated to the Director of Quality, NHS LCR; **DSR**

(C) a sample of the quality assurance proformas for CIP schemes with a value of >65k be circulated to the GRMC, for information, and **DSR**

(D) each Division (starting with the Acute Care Division) be requested to attend a monthly GRMC meeting to present the CIP proformas and ongoing process regarding quality impact assessments, KPIs, monitoring and actions to mitigate risk. **DSR/TA**

c. Quality, Safety and Experience Data - including analysis of any indicators that would indicate deterioration in the quality of services delivered

The Medical Director presented paper L, a report to provide assurance to the GRMC on quality, safety and patient experience within UHL during 2011-12. He advised that since December 2011, the Trust had been providing extra capacity beds in order to meet the additional emergency activity and a number of internal incidents had had to be called to deal with the pressure. In order to assure the quality of care, a review had been undertaken of key indicators spanning several years. The key indicators that were

reviewed included mortality, incidents, complaints and patient polling.

UHL's crude and risk adjusted mortality had been reviewed and it had been concluded that mortality remained within control limits and any variation outside that which might normally be expected seasonally had not been observed. UHL's risk adjusted mortality index, using the CHKS methodology (RAMI) had been 100 or below since February 2009. The Trust's RAMI for February 2012 was 91.

The number/rate of incident reporting varied between quarters, however, there did not appear to be any pattern to the variation. A marked increase to the number of EWS incidents reported from January 2012 to February 2012 had been noticed particularly in the Acute Division's emergency areas. In discussion, it was noted that 'responding to EWS triggers' was a work stream within the 5 critical safety actions and would be addressed through this project. Whilst incidents and complaints did not appear to have a pattern of variation, it seemed that the number and rate of SUIs followed a seasonal trend within an increase in both for quarter 3 and /or quarter 4. Responding to a query, it was noted that there had been a significant in-month variation in respect of pressure ulcers, but the overall trend from 2010 to 2012 had gone down.

Despite a rise in complaints, the overall rate remained low. There was no evidence from in-patient polling of a deterioration in the patient perception of the care provided. However, within the Medicine CBU, patient feedback was less positive. The Director of Nursing commented that patients on the extra capacity wards were polled, however there was no resource to report the data in the required format.

Members agreed for paper L to be shared with the PCT. The Committee Chairman suggested that this report be further discussed at the pre-meeting prior to the Trust Board meeting on 30 March 2012. **Chair**

<u>Resolved</u> – that the contents of paper L be received and noted and this report be further discussed at the pre-meeting prior to the Trust Board meeting on 30 March 2012. **Chair**

34/12/6a <u>PCT Quality Visits (December 2011 and January 2012) Update</u>

The Director of Clinical Quality advised that the PCT had undertaken quality visits to seek additional assurance regarding the quality of services provided to patients. UHL staff had only been informed 24 hours before the date of the intention to visit and ward areas were chosen by the PCT Cluster team and were undisclosed to UHL staff until arrival at the Trust. Concerns and comments were reported to the clinical staff directly to ensure that staff could respond to issues on a real time basis.

The Director of Quality, NHS LCR advised that papers M and M1 provided findings of the focussed quality visits undertaken in December 2011 and January 2012 respectively. In addition, some observational visits to the Emergency department, wards 15, 16 and additional wards at the LRI site has also been undertaken.

Mr P Panchal, Non-Executive Director sought assurance on whether staff had access to up-to date policies - in response, it was noted that in majority of cases, the policies were up to date on the Trust's SharePoint system. The Committee Chairman requested the Director of Quality, NHS LCR to circulate the template of the form used during the visits. **DoQ, NHS LCR**

<u>Resolved</u> – that (A) the contents of papers M and M1 be received and noted, and

(B) the Director of Quality, NHS LCR be requested to circulate the template of the forms used by the PCT during the quality visits. **DOQ, NHS LCR**

b. <u>Commissioner's Safety Concerns</u>

The Director of Quality, NHS LCR briefed members on the breach position relating to the delivery of the 62 day wait cancer target. She advised that robust discussions on the factors contributing to the delays and plans to improve the process had taken place. Discussions were underway on whether there was any significant harm due to this breach and further information from the Trust was awaited in order to get a better understanding of the issues. In response, the Divisional Director, Planned Care advised that the Cancer Board had been re-established and these issues would be further discussed through this forum. It was suggested that consideration be given to a CCG GP to be included on the membership of this Board.

The Divisonal Director, Planned Care confirmed that further work was being undertaken in respect of a small number of patients affected currently in excess of this waiting target. The Divisional Manager, Planned Care agreed to circulate the patient pathway report in respect of the breach position of these patients. In discussion, the Committee Chairman suggested that consideration be given to inviting one of the relevant patients (in respect of the 62 day wait breach) to provide feedback on their experiences to the Trust Board. **DM, PC** **MD**

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

(B) the patient pathway report in respect of the breach position of patients relating to the delivery of the 62 day wait cancer target be circulated to the GRMC, and **DM,PC**

(C) the Medical Director be requested to explore opportunities to invite one of the relevant patients (in respect of the 62 day wait breach) to provide feedback on their experiences – such information be circulated to a future meeting of the Trust Board, as appropriate. **MD/TA**

34/12/7 Report from the Director of Clinical Quality

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.

35/12 PATIENT EXPERIENCE

35/12/1 Implementation of the Friends and Family Test (Net Promoter Score)

Paper N provided an update on the implementation of the 'friends and family test' (Net Promoter Score). NHS Midlands and East had required all providers to use a generic question ("How likely is it that you would recommend this service to friends and family") in the in-patient surveys from 1 April 2012 to allow benchmarking across the cluster and care settings. Results from this 'Net Promoter' question needed to be obtained from 10% footfall of inpatients. The Strategic Health Authority would publish the results on NHS Local (a website where information on local NHS services was available) and in Board reports.

Following extensive consultation and feedback, four newly designed Inpatient Specialty Surveys (Adult Inpatient, Adult Daycase, Children's Inpatient and ITU) had been produced and were attached as appendices to paper N. Discussions had commenced between the Clinical Audit Team (who managed the collection, initial analysis and warehousing of the inpatient surveys) and the Information Team (who provided the high level calculation of the 'Net Promoter' score to report externally). Engagement with the clinical teams had begun, to facilitate this large scale change to ensure that a 10% return rate was gained.

Mr P Panchal, Non-Executive Director expressed concern that the children's inpatient survey questionnaire was not fit for purpose – in response, the Director of Nursing advised that this would be used as an opportunity to re-design the surveys.

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

36/12 SAFETY AND RISK

36/12/1 ED – Easter Cover Arrangements (discussion with Emergency Care Network Board)

The Chief Executive advised that the Emergency Care Network Board was scheduled to be held on 3 April 2012 and he agreed to provide an update on his discussions regarding the Easter cover arrangements to the Trust Board in April 2012.

Resolved – that an update on discussions with the Emergency Care Network Board in respect of Easter cover arrangements be provided to the Trust Board on 5 April 2012. **CE/TA**

36/12/2 Transferring patients from other hospitals

Resolved – that the Chief Executive be requested to liaise with the Chief Executives from other Acute Trusts and take a view on the local actions and the wider piece in respect of transferring patients from other hospitals and provide an update to the GRMC in April 2012. **CE/TA**

36/12/3 Patient Safety Report

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

- quarter 3 (2011-12) patient safety report;
- update on 5 critical safety actions;
- quality section of new Provider Management Regime;
- SUIs reported in February 2012;
- new SHA RCA timescales;
- CAS exception report, and
- UHL's 45- 60 day performance regarding completed RCA reports.

The Director of Safety and Risk brought members' attention to pages 9 and 10 of appendix 1 (quarter 3 patient safety report) of paper O which detailed the increase in the complaints relating to medical care and nursing care. However, there had been a 7.7% reduction in the number of complaints related to staff attitude compared with quarter 2. Overall, since quarter 1, there had been a 12.5% reduction in staff attitude complaints with the biggest decrease (58%) within the Women's and Children's Division.

A total of 51 new clinical claims had been received in quarter 3 which was an increase of 50% to the last quarter. The Trust actively encouraged the reporting of incidents and this was reflected within the National Patient Safety Agency data which was taken from the number of incidents submitted by the Trust to the National Reporting & Learning Systems.

In relation to the 5 critical safety actions (CSAs), the Director of Safety and Risk advised that a meeting had been held to discuss the proposed KPIs. However, as it had been challenging to establish KPIs for CSAs, it had been proposed that an implementation plan for each of the critical safety actions would be agreed and would need to be signed off by the Joint Governance session by the end of June 2012. It was noted that 16% of the CQUIN fund (£1.54m) had been attributed to the CSAs. Responding to a query, it was noted that a transformational funding application had been submitted to enable a project lead to be appointed for the 5 CSAs scheme and a response was awaited. The Committee Chairman and the Director of Quality, NHS LCR noted the need for the project manager appointment to go ahead as a matter of priority. It was suggested that the appointment of the project manager for the 5 CSA project be taken forward, outside the **DSR/ DFP/ COO/ CN/MD/ DCER**

meeting.

A total of 18 SUIs had been escalated during February 2012 (2 related to patient safety incidents, 10 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3 & 4) and 6 related to Healthcare Acquired Infections).

Divisions were making the necessary arrangements to accelerate the completion of RCA reports in respect of the new timescales (45 days).

Resolved – that (A) contents of paper O be received and noted; **DSR/ DFP/ COO/ CN/MD/ DCER**

(B) the appointment of the project manager for the 5 Critical Safety Actions be taken forward outside the meeting.

36/12/4 Monitoring of Falls

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

36/12/5 Report from 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.

36/12/6 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.

37/12 ITEMS FOR INFORMATION

37/12/1 Internal Audit's Review of Risk Management Processes with UHL

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

37/12/2 Update on HSE Visit – 7 March 2012

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

37/12/3 East Midlands Children's and Young Persons' Integrated Cancer Service (EMCYPICS) – Response to concerns raised by the National Cancer Peer Review

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

37/12/4 Quarter 3 (October-December 2011) Report from Clinical Effectiveness Committee

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

38/12 MINUTES FOR INFORMATION

38/12/1 Finance and Performance Committee

Resolved – that the Minutes of the 22 February 2012 Finance and Performance Committee meeting (paper W refers) be received for information.

39/12 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

40/12 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 5 April 2012 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

- **Planned Care Division – Complaints Performance (Minute 33/12/1a refers);**
- **Complaints Management (Minute 33/12/1 c refers) ;**
- **Draft Annual Operational Plan 2012-13 (Minute 34/12/5a refers);**
- **CIPs 2012-13 Safety and Quality Assurance Process (Minute 34/12/5b refers), and**
- **Report from the Director of Clinical Quality (Minute 34/12/7 refers).**

41/12 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 26 April 2012 from 1:00pm in Conference Rooms 1A&1B, Gwendolen House, Leicester General Hospital.

Post meeting note:-As the Trust Board meeting will be held on 26 April 2012, the next meeting of the Governance and Risk Management Committee will be held on Monday, 23 April 2012, 1pm-4pm in the Cedar Room, Knighton Street Offices, Ground, Floor, Leicester Royal Infirmary.

The meeting closed at 5:20pm.

Hina Majeed,
Trust Administrator