Trust Board Paper G

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: 28 June 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 21 May 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:

- The requirement for a Trust Board Development session on SRR/BAF (discussion under Minute 56/12/4 refers);
- Recent Electronic Prescribing failure/reduction in falls and pressure ulcers and update on Net Promoter score (discussions under Minute 57/12/3 refers) ;
- Critical Care/HDU – capacity/resource issues (discussion under Minute 57/12/3 refers);
- Revised Q&P report (discussion under Minute 57/12/3 refers), and
- Quarter 4 (2011-12) Clinical Audit Report (Minute 57/12/7 refers).

DATE OF NEXT COMMITTEE MEETING: 25 June 2012

Mr D Tracy
21 June 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON MONDAY 21 MAY 2012 AT 1:30PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Dean of the University of Leicester Medical School

In Attendance:
Ms D Baker – Service Equality Manager (for Minute 57/12/1)
Dr B Collett – Associate Medical Director, Clinical Effectiveness
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Mrs C Ribbins – Director of Nursing/Deputy DIPAC
Ms C Trevithick – Chief Nurse and Quality Lead, West Leicestershire CCG
Ms K Wilkins – Divisional Head of Nursing, Women's and Children's (for Minutes 56/12/1, 56/12/2, 57/12/9 and 60/12/1)
Mr D Yeomanson – Divisional Manager, Women's and Children's (for Minutes 56/12/1, 56/12/2, 57/12/9 and 60/12/1)

ACTION

RESOLVED ITEMS

53/12 APOLOGIES AND WELCOME

Apologies for absence were received from Dr D Briggs, Chair, East Leicestershire & Rutland CCG; Mr M Caple, Patient Adviser; Mr M Lowe-Lauri, Chief Executive; Mr P Panchal, Non-Executive Director; Mr S Ward, Director of Corporate and Legal Affairs and Mr M Wightman, Director of Communications and External Relations.

The Committee Chairman welcomed Ms C Trevithick, Chief Nurse and Quality Lead, West Leicestershire CCG to the meeting.

54/12 MINUTES

In respect of Minute 47/12/1, the Director of Safety and Risk noted an amendment to point (b) advising that examples of completed risk assessments for schemes with a quality impact score of 12 or above had been provided to the CCG Chair. **TA**

Resolved – that subject to the above correction, the Minutes (papers A and A1) from the meeting held on 23 April 2012 be confirmed as a correct record. **TA**

55/12 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. In respect of Minute 48/12, the Committee Chairman requested that a report on the changes to the GRMC terms of reference and the new requirement regarding attendance thresholds be provided to the GRMC meeting in June 2012. **DCLA**

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

(B) a report on the changes to the GRMC terms of reference and the new requirement regarding attendance thresholds be provided to the GRMC meeting in June 2012. **DCLA/ TA**

55/12/1 Health and Safety Report - Reviewing the timetable for annual health and safety and risk management self assessment audits to avoid winter capacity pressures

Further to Minute 47/12/4 of 23 April 2012, the Director of Safety and Risk advised that the Senior Health and Safety Manager would be working with Divisions to consider moving the annual health and safety and risk management self assessment audits in order to get better compliance, noting that the Health and Safety Team were still following-up non-submissions and late submissions of audits where appropriate.

Resolved – that the position be noted.

56/12 SAFETY AND RISK

56/12/1a Cost Improvement Programme 2012-13 Assurance re: Quality and Safety Standards

The Director of Safety and Risk advised that Clinical Divisions and Corporate Directorates had been asked to identify CIP schemes with a value of over £65k and/or risk score of 12 or above in relation to patient safety/quality of care. From a total of 310 CIP schemes, six schemes were identified as having a risk score of 12 or above (paper C refers). These schemes were risk assessed and key performance indicators (KPIs) had been identified so that they could be monitored to ensure that the schemes were not having an adverse impact upon patient safety/quality of care. A process was in place to report to the GRMC (by exception) regarding those schemes where a deteriorating position in relation to safety/quality was identified. **DSR**

Responding to a query, it was noted that the Risk and Assurance Manager was in liaison with the Divisional teams on a monthly basis in order to scrutinise the score ratings and test the KPI monitoring arrangements and it was noted that there was no deterioration in position in April 2012. In response to a query on how GRMC would be made aware if there was an issue with any of the schemes, members were advised that at the monthly confirm and challenge meetings, Divisions were required to provide an update on the KPI position and flag RAG ratings. The Director of Safety and Risk confirmed that a rigorous process was in place to ensure that schemes did not impact upon safety and quality of care and Divisional presentations had been arranged for the GRMC to review any areas of concern.

The Associate Medical Director highlighted that the CIP scheme from the Acute Care Division in respect of 'reduction of 6.0 FY2 doctors expected from August 2012' was mandated by the Deanery and could not be considered as a CIP scheme.

The Committee Chairman suggested that assurance be provided to GRMC re: effective management of those CIP schemes where any risk to patient safety/quality of care had been identified. **DSR**

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

(B) assurance be provided to the GRMC meeting in July 2012 re: effective management of those CIP schemes where any risk to patient safety/quality had been identified, and **DSR/TA**

(C) a monthly exception report be provided to GRMC outlining those CIP schemes where a deteriorating position in relation to patient safety/quality of care had been identified. **DSR/TA**

56/12/1b Divisional CIP Presentation: Women's and Children's Division

The Divisional Manager and Divisional Head of Nursing from the Women's and Children's Division attended the meeting to present an update on their Divisional CIP schemes and the ongoing process to complete quality impact assessments, monitoring arrangements and actions to mitigate any identified risks (the presentation was tabled at the meeting).

The Divisional budget was £87.807m and the current CIP value identified was £1.398m.

The following workstreams had been undertaken to identify potential CIP opportunities:-

(a) multi disciplinary CIP workshops with CBUs facilitated by Finnamore;
(b) a deep dive review of Women's CBU by an external Consultant;
(c) Consultant meetings, and
(d) a review of CIP schemes shared through Women's Services Provider Alliance.

For each CIP scheme, a standard risk assessment had been completed by the CBU including any actions necessary to mitigate risk. For schemes with a value of over £65k, KPIs had been identified. Both the CBUs in the Division had specific dashboards and the KPIs were monitored through the quality and risk assessment process. Each CBU had developed a project plan with milestones for each significant scheme and fortnightly Divisional CIP assurance meetings were held. An approach called 'adopt a ward' had been created so that CBU managers could visit a ward and liaise with all levels of staff to cascade information and also pick up/address any issues.

In response to a query from Professor D Wynford-Thomas, Non-Executive Director, it was noted that some schemes might be viable but would take longer than expected to progress - in this case it would be necessary to have mitigating actions in place and re-programme when the savings would be delivered, however for schemes which slipped, there was a need to develop other mitigating schemes in order to deliver the savings. Each CIP scheme had a Senior Responsible Officer, however the CBU and ultimately the Division had the total control on the progress of the schemes.

The Committee Chairman commented on the relatively low percentage of CIP schemes identified by the Women's and Children's Division in comparison to the other Divisions and queried whether there was a possibility to develop further potential schemes - in response, the Chief Operating Officer/Chief Nurse advised that discussions had been held with the Division and currently there were no further ideas, however this would be further explored with the Division and it was preferable to include schemes that were achievable rather than having a blanket percentage across all the Divisions. The Divisional Manager highlighted that the Division had been in liaison with the Executive Team and there were opportunities for CIPs in the future particularly in relation to the models of Antenatal Care.

Resolved – that the tabled presentation and the additional verbal update be received and noted.

56/12/2 Report from the Director of Safety and Risk

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.

56/12/3 Patient Safety Report

The Director of Safety and Risk presented paper D, a summary of key patient safety issues, which covered the following:-

- 2011-12 quarter 4 patient safety report (appendix 1 refers);
- provider management report - April 2012 data;
- update on recent electronic prescribing failure, early warning scores and 5 critical

safety actions;
- SUIs reported in April 2012;
- CAS exception report, and
- UHL's 45- 60 day performance regarding completed RCA reports.

The Director of Safety and Risk brought members' attention to the executive summary of the quarter 4 (1 January 2012- 31 March 2012) patient safety data which was provided under section 2.2 of paper D. The quarter 4 data revealed a modest improvement in re-opened complaints, the number of formal complaints received and cases accepted by the Ombudsman. There had been an increase in incidents reported and a deterioration in the 45-60 RCA performance. Professor D Wynford-Thomas, Non-Executive Director highlighted that the graphs in the quarterly report had depicted the trends exceptionally well, however this had not been appropriately reflected in the text of the report/executive summary.

Responding to a query from Ms J Wilson, Non-Executive Director, the Director of Nursing and Chief Operating Officer/Chief Nurse confirmed that there was a correlation between complaints trends and those wards participating in the 'Releasing time to care project'. This was captured in the specific dashboards and members were advised that a six monthly update on poor performing wards had already been scheduled to be presented to the GRMC.

Members noted the need for winter planning work to commence soon and for consideration to be given to things that could be done differently noting that there were significant pressures on the system and targets were more challenging. The Committee Chairman suggested that an update on the review of the winter planning work be provided to the GRMC in September 2012. **COO/CN**

Members were sighted to the table on page 6 of paper D which detailed the quality and safety performance section of the provider management regime monthly monitoring tool. The table set out the information returned by UHL specifically related to serious incidents. The Chief Operating Officer/Chief Nurse commented on the high number of open incidents - in response, the Director of Safety and Risk advised that previously the number of incidents open in-month were provided, however, the SHA had requested a cumulative figure - therefore this detail had now been provided which also included a commentary. Divisions had advised that the current number of incidents requiring investigation and review was placing extreme pressure on the Divisional quality teams.

Ten EWS incidents were reported in April 2012, which represented a decrease from the previous months. In relation to the recruitment of a project manager for the 5 critical safety actions project, it was noted that interviews were being held.

The Patient Safety Team continued to pay considerable attention to analysing the underlying causes of clinical errors. The Director of Nursing mentioned about the Nursing Showcase where some fabulous examples of the work undertaken by nurses in UHL were exhibited.

The Associate Medical Director informed members of a recent major failure of the electronic prescribing system on 19 April 2012 when the system became unstable and produced error messages to users. The key issue was that the error affected the business continuity element of the system and clinicians could not access the off-line drug charts. However, no patients were at risk as the users could see the patients' medication information but just could not effectively use the system. The supplier had fully investigated the issue and the cause of the error was that the message queue that sent the data from the system to the offline chart built up and reached its maximum level of 11,000 messages. A monitoring system had now been put in place to alert if the message queue built up more than 9 messages thereby allowing sufficient time to correct the error before it affected the system stability. It was noted that the risk register had been updated to reflect this issue. Responding to a query from the Chief Operating Officer/Chief Nurse

on whether the system would confidently cope the roll-out in further wards, it was noted that the supplier was scrutinising the system and the roll-out would not be an issue, however, the delay in the training of appropriate staff might limit the speed of roll-out.

A total of 20 SUIs had been escalated during April 2012 (6 related to patient safety incidents, 12 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3 & 4) and 2 related to Healthcare Acquired Infections).

Appendix 2 to paper D provided a summary of the outstanding NPSA CAS alerts and their estimated timescales for completion. Section 8 of paper K detailed progress of the arrangements to accelerate completion of RCA reports.

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

(B) an update on the review of the winter planning work be provided to the GRMC in September 2012. **COO/CN/TA**

56/12/4 Risk Management Report

Paper E provided GRMC with an update in respect of the Trust's Strategic Risk Register/Board Assurance Framework (SRR/BAF), organisational risks scoring 15 or above and developments in the risk management process. The risk awareness training for senior managers was now part of UHL's statutory and mandatory training programme and was facilitated by the Risk and Assurance Manager. Actions recommended by Internal Audit further to the risk management review were being implemented.

In respect of the 'IT- Financial and Operational Implications (ED)' risk within the organisational risk register with a current risk score of '25' - it was noted that discussions were ongoing with the CBU to review the risk score and expedite the progress with the actions recorded in the 'action summary' column.

In discussion on risk 5 on the strategic risk register 'Lack of appropriate PbR income' - the Chief Operating Officer/Chief Nurse advised that the coding programme had been rolled out and EDIS was being updated; however, the remuneration was dependent on which area the patient was being treated in. There was a need to find a way to manage the gap as this would be a potential cost issue to Commissioners and income lost to the Trust.

The Committee Chairman suggested that a report on the review of 3-4 risks which had been open on the risk register for more than 3 years be presented to the GRMC in July 2012. In discussion, the Medical Director noted the need for a Trust Board development session on the Strategic Risk Register/Board Assurance Framework to be arranged. **DSR**

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

(B) a report on the review of 3-4 risks which had been open longer than three years on the risk register be presented to the GRMC in July 2012. **DSR/TA**

56/12/5 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.

57/12 QUALITY

57/12/1 Update on Equality Delivery System (EDS) Implementation and Six Lives Action Plan

The Service Equality Manager attended the meeting to present paper F, a report to update the Committee on progress against the EDS implementation plan and Six Lives

action plan. The equality objectives (appendix 1 refers) had been agreed and had been published on the UHL web page, thereby complying with the Public Sector Duty which required external publication by 6 April 2012.

In respect of Six Lives progress, UHL declared full compliance to the SHA at year-end (2011-12). The SHA's reporting format had been slightly altered for 2012-13 and had some additional performance indicators.

A further update on EDS implementation plan and six lives action plan would be provided to the GRMC in November 2012. **SEM**

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

(B) a further update on EDS implementation plan and six lives action plan be provided to the GRMC in November 2012. **SEM/TA**

57/12/2 Nursing Metrics and Extended Nursing Metrics

Paper G summarised progress against the nursing metrics for the period August 2009 to April 2012. The Chief Operating Officer/Chief Nurse reported that the results for April 2012 remained reasonably consistent with the 'Resuscitation' indicator showing isolated cases of non-compliance and the 'VTE' indicator being consistent with ward clerk recording. During 2012, the Trust would be subject to a CQUIN relating to a suite of discharge targets with immediate effect which would link directly with the metric reporting. Members noted in-month improvements in 10 of the 13 metrics in place, whilst the remaining 3 metrics had maintained their performance.

Paper G1 detailed the extended nursing metrics in place within 8 specialist areas across the Trust. It was noted that theatre recovery and day surgery had maintained 'green' status in all areas.

Extra capacity wards had been a focus of extended audit due to the fluid nature of the ward and flexible labour – the outcomes were appended to paper G1 for the relevant dates when such capacity had been open. The Committee Chairman noted the deteriorating performance in these wards and suggested that matrons of high performing wards take charge of leadership of these wards - in response, it was noted that consideration was being given to this suggestion with a recent change in ward leadership within one extra capacity ward. The Chief Operating Officer/Chief Nurse also commented that such wards were not run by consistent nursing staff and this did have a major impact on the scores achieved. There was a need to be more efficient with a structured and permanent workforce in such areas. The Chief Nurse and Quality Lead, West Leicestershire CCG noted that most of the extra capacity wards had scored 'red' for the 'Resuscitation' indicator and queried whether this was due to the non-availability of the equipment - in response, it was noted that even minor lapses in documentation processes might have led to the reduced scores within this indicator. The Associate Medical Director stressed the need for consistency in how medical staff managed patients in these ward areas - in response, the Medical Director confirmed that he had discussed this issue and the Head of Operations would be circulating guidance to the medical staff.

Resolved – that the contents of papers G and G1 be received and noted.

57/12/3 Quality, Finance and Performance Report – Month 1

Papers H and H1 detailed the quality, finance and performance report, heat map and associated management commentary for month 1 (month ending 30 April 2012). The Chief Operating Officer/Chief Nurse reported on key issues, as follows:-

a) no MRSA cases reported in-month and for the third consecutive month;
b) 14 cases of C Difficile reported in April 2012 which was above trajectory, however the

number of cases for May 2012 was none to date;

c) performance for type 1 & 2 met April's trajectory set in the remedial plan, however, performance remained variable. A further report on ED activity would be provided to the May 2012 Trust Board. Appendix A detailed the results for the UHL Emergency Department Patient Report for April 2012;
d) an increase in the number of pressure ulcers reported;
e) 1854 patient experience surveys were returned in April 2012 which was the largest number of surveys ever received in one month;
f) UHL's overall Net Promoter score for April 2012 was 51 and data coverage had been achieved. The SHA would be using this score as the main measure of patient experience;
g) an improvement in cancelled operation performance. The Trust was taking forward both short and longer term improvement actions (appendix B refers) designed to reduce hospital cancelled operations, and
h) three unjustified same sex accommodation breaches affecting 7 patients were reported. In discussion on this, it was noted that Commissioners would need to follow guidance on financial penalties due to these breaches.

The Chief Operating Officer/Chief Nurse expressed concern that UHL did not have adequate capacity/resource to manage patients who required high dependency/critical care. She welcomed a wider debate on this issue at a future meeting of the GRMC. Further to this concern, Ms J Wilson, Non-Executive Director commented that within appendix B (revised action plan to reduce hospital cancelled operations) - the action relating to 'additional critical care bed capacity across Trust sites' had been rated 'green' - in response, the Chief Operating Officer/Chief Nurse confirmed that the action plan for critical care capacity and cancelled operations were two different strands and she agreed to make this clear within future reports. **COO/CN**

The proposed changes to the content and format of the 2012-13 Quality and Performance (Q&P) report were provided as appendix C to paper H. The report has been updated to include the indicators in the 2012-13 Operating Framework and 2012-13 Provider Management Regime. Whilst duplication of some indicators might be apparent, it was important to note that monitoring periods and scoring might be different. Members were requested to provide comments on the revised Q&P report outside the meeting. The Chief Operating Officer/Chief Nurse agreed to forward the revised Q&P report to Commissioners for their comments. **ALL** **COO/CN**

In relation to theatre scheduling, it was noted that the roll-out plan was discussed at the May 2012 Transformation Board meeting and would be taken forward through the transformational work stream.

The Medical Director reported that the Trust now had access to the Dr Fosters Intelligence (DFI) clinical benchmarking system which used the 'Hospital Standardised Mortality Rate' (HSMR). This mortality indicator appeared to correlate more closely with the new national SHMI. UHL's HSMR for March 2011 to February 2012 was 93.2 which was better than expected when compared with the 'Better Care Better Value' peers.

In order to improve the Trust's fractured neck of femur (#NOF) performance, the plans for establishing a dedicated #NOF ward had been brought forward to end of June 2012.

In discussion on end of life care pathways, the Medical Director advised that robust end of life care pathways were not available, however this was not a UHL solution and work needed to be undertaken with public health to resolve issues in this respect. As Chair of the End of Life Care Group, the Director of Nursing agreed to provide a report to the GRMC meeting in June 2012. It was also noted that CCGs were leading a work stream on end of life care. **DoN**

<u>Resolved</u> – that (A) the quality and performance report and divisional heat map for month 1 (month ending April 2012) be noted;

(B) a discussion on resource/capacity issues in the High Dependency Unit/Critical Care be scheduled on the agenda for a future meeting of the GRMC; **COO/CN/TA**

(C) the revised Q&P report be forwarded to Commissioners for comments; **COO/CN**

(D) comments on the revised Q&P report be sent to the Chief Operating Officer/Chief Nurse outside the meeting, and **ALL**

(E) an update on the work surrounding End of Life Care in UHL be presented to the GRMC in June 2012. **DoN/TA**

57/12/4 CQC Visit - Inspections of Wards 15 and 16 - Update

Further to Minute 45/12/4 of 23 April 2012, the Director of Clinical Quality advised members that the CQC had re-visited wards 15 and 16 at the LRI on 4 May 2012. They had now found UHL compliant and had noticed that the use of trolleys on the AMU had been suspended. A report on the CQC's visit would be published on UHL's public website.

Resolved – that the position be noted.

57/12/5 CQC Risk Summit - 30 April 2012

The Director of Clinical Quality reported that she had attended the Risk Summit on 30 April 2012 along with the Chief Operating Officer/Chief Nurse and Medical Director. Representatives from the CCG Cluster, SHA, Deanery and CQC also attended. Further to the meeting, the notes of the meeting had been received. UHL had concerns on the accuracy of the notes and this was expressed to the CQC. Responding to a query from the Committee Chairman, the Director of Clinical Quality agreed to circulate the Trust's comments to the CQC in respect of the notes of the Risk Summit held on 30 April 2012. **DCQ**

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

(B) the Director of Clinical Quality be requested to circulate the Trust's comments to the CQC in respect of the notes of the Risk Summit held on 30 April 2012. **DCQ/TA**

57/12/6 Quality Accounts 2011-12 Update

The Director of Clinical Quality presented paper I, an update to the GRMC on progress with the Quality Account including:-

- feedback from stakeholders;
- requirement for external assurance, and
- the statement of Directors' responsibilities (appendix 1 refers).

The Trust's External Auditors would be reviewing the final draft Quality Account together with stakeholders' commentary and would be asked to provide their opinion.

Appendix 2 detailed the commentary received from Commissioners, Leicestershire LINks and County OSC. Additionally, Commissioners provided more detailed comments which were detailed in appendix 3. In discussion on the additions requested by Commissioners, the Chief Nurse and Quality Lead, West Leicestershire CCG acknowledged that the comments had been provided at a late stage and agreed that it was the Trust's discretion on how it would prefer to make use of the comments. It was agreed that the Quality Account would be reviewed to include any material changes and the final draft would be presented to the GRMC in June 2012. **DCQ**

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

(B) the final draft of the Quality Account be presented to the GRMC in June 2012. **DCQ/TA**

57/12/7 Quarter 4 (2011-12) Clinical Audit Report

The Director of Clinical Quality presented paper J, a report on progress with delivering the UHL Clinical Audit Programme in terms of current activity and implementing actions agreed as a result of completed clinical audits. The following points were highlighted in particular:-

(a) continued increase in the number of audits registered and proportion of completed audits (rose by a further 9%). The number of completed audits across the Trust was significantly higher than 2010-11;
(b) introduction of Specialty clinical audit dashboards to profile progress against 3 key indicators;
(c) 17% of audits had been flagged as 'amber' in terms of progress - most of these were delayed at the action planning stage, and
(d) a new process for monitoring actions implemented continued to be rolled out and training had been provided to audit leads. The action plan would not be signed-off unless all actions were completed.

Professor D Wynford-Thomas, Non-Executive Director noted the step forward and improvements made to monitor the action plan and welcomed the changes to this report.

It was suggested that a Division be invited to attend a GRMC meeting to provide an update on the good practice/improvements made following a clinical audit. **DCQ**

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

(B) a Division be invited to attend a future meeting of the GRMC to provide an update on the good practice/improvements made following a clinical audit. **DCQ/TA**

57/12/8 PCT Quality Visit (March 2012) Update

Paper K detailed the findings of the PCT Cluster following quality visits to all 3 sites in March 2012.

Responding to a query from the Committee Chairman, the Chief Operating Officer/Chief Nurse commented that the visits were undertaken professionally and the feedback was useful. However, she expressed concern that when the findings were reported externally, there seemed to be a focus only on the negative issues where as the positive findings were not appropriately reported and she noted a need for a balance. The Chief Nurse and Quality Lead, West Leicestershire CCG acknowledged the concern raised and advised that in her next quality and governance report to the PCT Cluster Board, she would include both the positive and negative findings. She commented that the Non-Executive members of the PCT Cluster and GPs sought positive assurance following these visits.

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

57/12/9 External Review of Maternity Services

The Chief Nurse and Quality Lead, West Leicestershire CCG advised that there was a need to undertake a deep dive on the risk mitigation actions put in place by the Women's CBU in respect of patient safety issues in maternity relating to 3rd and 4th degree tears, blood loss and CTG training. Therefore, Commissioners and representatives from the Women's CBU met on 21 May 2012 (paper L refers) and a number of actions had been agreed to use data differently so that themes and trends could be monitored appropriately. A robust discussion on the subjectivity and interpretation of CTG and ideas around reporting SUIs were also held at this meeting. The Divisional Manager, Women's and Children's acknowledged that it was a positive meeting and it was a start of a good

relationship between CCGs and the Division.

Resolved – that the position be noted.

57/12/10 Update on Hospital Acquired Pressure Ulcers (HAPUs)

Paper M detailed the annual report on hospital acquired pressure ulcer data in UHL for 2011-12.

The Director of Nursing reported that there had been a gradual reduction in the numbers of HAPUs across the Trust that began in July 2011 and continued throughout the year achieving an approximate 36% reduction in ulcers when comparing data from 2010-11. Throughout 2011-12, the five CQUIN wards achieved improvement thresholds with significant reductions in grade 3 and 4 ulcers of between 61% and 88%. Key risk areas in relation to the prevention and management of pressure ulcers had been identified.

Section 4 detailed the SHA's ambition to eliminate all avoidable grade 2, 3 and 4 pressure ulcers by 31 December 2012. This was an ambitious challenge for all Trusts, nevertheless, it had been evident that some UHL wards (which had previously reported a high incidence rate) involved in the CQUIN had achieved significant reductions over 2011-12 with supportive performance management and targeted training and practice development. Implementation of the safety thermometer had also been achieved. On 31 May 2012, the SHA 'Pressure Ulcer Intensive Support Team' would be visiting the Trust to meet staff in order to establish the support that the Trust might need to achieve the SHA ambition.

Responding to a query from the Director of Safety and Risk in relation to the table (percentage of avoidable/unavoidable ulcers 2011-12) on page 3 of paper M, the Director of Nursing confirmed that some historic data in respect of pressure ulcers had not been classified in these two categories and therefore had been reported within the column labelled 'outstanding'.

Ms J Wilson, Non-Executive Director queried whether actions were in place to mitigate risk in the Medicine CBU as this was the area that reported the highest numbers of avoidable HAPUs - in response, it was noted that support was currently available to significantly change practice at ward and CBU level, however this needed to be closely monitored.

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

58/12 ITEMS FOR INFORMATION

58/12/1 Actions taken to improve medication safety in children

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

58/12/2 Data Quality Performance Report

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

58/12/3 Infection Prevention Toolkit Annual Programme 2012-13

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

58/12/4 **Quarter 4 (January – March 2012) Report from Clinical Effectiveness Committee**

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

58/12/5 **UHL Readmissions Independent Review**

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

59/12 MINUTES FOR INFORMATION

59/12/1 Finance and Performance Committee

Resolved – that the Minutes of the 25 April 2012 Finance and Performance Committee meeting be presented to the GRMC on 25 June 2012.

60/12 ANY OTHER BUSINESS

60/12/1 Report from the Divisional Manager, Women's and Children's

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.

61/12 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 28 May 2012 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

- Report from the Director of Safety and Risk (Minute 56/12/2 refers);
- The requirement for a Trust Board Development session on SRR/BAF (discussion under Minute 56/12/4 refers);
- Recent Electronic Prescribing failure/reduction in falls and pressure ulcers and update on Net Promoter score (discussions under Minute 57/12/3 refers) ;
- Critical Care/HDU – capacity/resource issues (discussion under Minute 57/12/3 refers);
- Revised Q&P report (discussion under Minute 57/12/3 refers), and
- Quarter 4 (2011-12) Clinical Audit Report (Minute 57/12/7 refers).

62/12 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Monday, 25 June 2012 from 1:30pm in the Board Room, Victoria Building, Leicester Royal Infirmary. **TA**

The meeting closed at 4:34pm.

Hina Majeed
Trust Administrator