Trust Board Paper I

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: 30 AUGUST 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 23 July 2012

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

- Trust Board approval of the 2011-12 GRMC Annual Report (Minute 75/12) (report appended to the minutes)

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

- Acute Care Division complaints performance data Quarter 1 -2012 -13 (Minute 78/12/1 refers);
- Review of Nursing Acuity and discussion re: HDU Capacity and Clinical Summit (Minute 79/12/5 refers) , and
- SHA Intensive Support Team Review of Pressure Ulcers and Recommendations for Practice (Minute 80/12/3 refers).

DATE OF NEXT COMMITTEE MEETING: 20 August 2012

Mr D Tracy
23 August 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON MONDAY 23 JULY 2012 AT 1:30PM IN THE CEDAR ROOM, KNIGHTON STREET OFFICES, LEICESTER ROYAL INFIRMARY

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Dr D Briggs – Chair, East Leicestershire & Rutland CCG (non voting member)
Mr M Caple – Patient Adviser (non voting member)
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Mr P Panchal – Non-Executive Director (until part-Minute 78/12/5)
Ms C Trevithick – Chief Nurse and Quality Lead, West Leicestershire CCG (non voting member)
Mr S Ward – Director of Corporate and Legal Affairs
Ms J Wilson – Non-Executive Director

In Attendance:
Ms S Adams – Quality and Safety Manager (for Minute 78/12/1)
Dr B Collett – Associate Medical Director
Miss M Durbridge – Director of Safety and Risk
Ms M Harris – Divisional Manager, Acute Care (for Minute 78/12/1)
Ms H Jones – Quality and Safety Manager, Clinical Support (for Minutes 78/12/2 & 78/12/3)
Ms H Killer – Children's CBU Manager (for Minute 78/12/4)
Ms H Leatham – Head of Nursing, Patient Experience (for Minute 78/12/5 & 78/12/6)
Ms S Mason – Divisional Head of Nursing, Acute Care (for Minute 78/12/1)
Mrs E Ryan – Divisional Head of Nursing, Clinical Support (for Minutes 78/12/2 & 78/12/3)
Dr D Skehan – Divisional Director, Acute Care (for Minute 78/12/1)
Mr C Walker – Clinical Audit Manager (for Minutes 78/12/5 & 78/12/6)

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Tracy (Chair)	4	4	100%	C Trevithick*	3	3	100%
D Briggs*	4	2	50%	S Ward	4	2	50%
M Caple*	4	2	50%	M Wightman	4	1	25%
K Harris	4	3	75%	J Wilson	4	3	75%
S Hinchliffe	4	4	100%	D Wynford-Thomas	4	2	50%
P Panchal	4	3	75%				

* non-voting members

RECOMMENDED ITEM

75/12 GRMC Annual Report 2011-12

Paper O detailed the GRMC Annual Report 2011-12 which would also be submitted to the Trust Board with these Minutes. The Committee Chairman and the Director of Safety and Risk agreed to provide comments on the report to the Director of Corporate and Legal Affairs, outside the meeting. Subject to inclusion of these comments, the report was recommended for Trust Board approval and appended to the Minutes of this meeting accordingly. **Chair/ DSR** **DCLA**

Resolved – that (A) comments on the GRMC annual report be provided to the Director of Corporate and Legal Affairs outside the meeting, and **Chair/ DSR**

(B) the 2011-12 GRMC annual report be recommended for Trust Board approval and appended to the Minutes of this meeting accordingly. **DCLA/ TA**

RESOLVED ITEMS **ACTION**

76/12 APOLOGIES

Apologies for absence were received from Mr J Birrell, Chief Executive; Mrs S Hotson, Director of Clinical Quality; Mrs C Ribbins, Director of Nursing; Mr M Wightman, Director of Communications and External Relations and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

77/12 MINUTES

Resolved – that the Minutes of the meeting held on 25 June 2012 be confirmed as a correct record.

78/12 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 July 2011. Members noted in particular:-

- Minute 66/12/5 – the Director of Corporate and Legal Affairs agreed to discuss with the Director of Communications and External Relations in respect of consideration being given to removing the spoken automated message re: UHL being a non-smoking site, at hospital entrances. **DCLA/ DCER**

Resolved – that the matters arising report and the action above, be noted. **DCLA/ DCER**

78/12/1 Complaints Performance Data – 2012-13 (Quarter 1)

The Divisional Director, Divisional Manager, Divisional Head of Nursing and Quality and Safety Manager from the Acute Care Division attended the meeting to present an update on the formal complaints received in the Division in quarter 1 of 2012-13 and indicate whether there had been a trend towards reduction in complaints.

In discussion on paper C, members queried:-

(i) the impact that had been made since maximising Matron presence on wards – it was noted that Matrons linked with the staff to ascertain whether there were any such issues and attempted to resolve when patients were on the ward. This had therefore ensured proactive responses to patient/relative concerns with immediate action/resolution;

(ii) the actions that had been put in place following the significant increase in complaints in the Emergency Department – in response, members were advised that robust discussions had been held on ways to respond to complaints. This had now been the focus and associated learning was being integrated into the emergency flow work and the revised governance arrangements in the department. A Consultant of the week was being designated to resolve any issues, and

(iii) the issues covering complaints relating to medical care – it was highlighted that this comprised a variety of issues ranging from 'missed fractures' to 'communication' issues. There was a need to understand the rise in complaints in this category. The current focus was on improving the emergency care of patients

which would inevitably improve the patient's experience and it was anticipated that this would subsequently reduce complaints.

Members were impressed that follow-up phone calls were made to patients/ relatives/carers 48 hours after discharge to check that all services planned were in operation.

The Divisional Director highlighted that a new Consultant in the Emergency Department had been appointed with 1 PA to focus on governance issues. It was also noted that number of complaints in comparison to the activity numbers was not high. The Divisional Manager advised that all incidents and complaints in the last 12 months were being reviewed to ascertain the root causes and understand whether any obvious themes had been overlooked.

The Director of Safety and Risk commented that the Division had seen a reduction in complaints in the Medicine CBU and the quality of complaint responses had also improved. She queried whether the Division was on target to achieve the 10% reduction in formal complaints by quarter 4 of 2012-13 – in response, it was noted that the Division was determined to do so.

The Committee Chairman requested that each Division attended the GRMC meeting on a rotating monthly basis from April - July 2013 to provide an update on complaints performance and progress in achieving the 10% reduction in formal complaints in 2012-13. **ALL DIVS**

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

(B) from April – July 2013, each Division to attend the GRMC meeting on a rotating monthly basis to provide an update on complaints performance and progress in achieving the 10% reduction in formal complaints in 2012-13. **ALL DIVS/TA**

78/12/2 <u>Clinical Support Division – Complaints handling, management, annual performance, plans and benchmarking information</u>

The Divisional Head of Nursing and the Quality and Safety Manager, Clinical Support Division attended the meeting to present paper D, a report to provide assurance that the Division had clear governance arrangements and reporting processes both internally and externally to the organisation, to ensure patient and staff safety.

Responding to a query, the Divisional Head of Nursing advised that staff were encouraged to meet the patient/relative/carer and resolve issues on an immediate basis and the Divisional Quality and Safety Team assisted in taking this forward. For example, if there was a need to cancel an operation then the Divisional Head of Nursing or a member of her team would personally explain the situation to the patient and would attempt to provide a new date for the operation.

In response to a query from the Patient Adviser, it was noted that 'clinical care' and 'medical care' complaints were logged as two different categories on Datix. In response to a further query on the reason for the high number of complaints in the Physiotherapy team, the Quality and Safety Manager highlighted that all complaints were discussed at Divisional Board meetings and there were no particular concerns in this Specialty. It was noted that the rise in complaints in this Specialty might be linked to the increase in patient falls.

The monthly Quality Forum meetings which had representation from all CBUs of the Division also discussed patient complaints.

Mr P Panchal, Non-Executive Director queried whether the complaint numbers included complaints from other Divisions as the Clinical Support Division provided a service to other parts of the organisation – in response, it was noted that this report focused only on patient related complaints. However, all other complaints received by the Division would be logged on Datix and the Division would meet with the respective Divisional/CBU staff to resolve issues.

In response to a query from the Chair, East Leicestershire & Rutland CCG, members were advised that no particular themes had been identified in relation to the increase in clinical care complaints.

The Director of Safety and Risk queried the target actions taken to resolve complaints in the Imaging and Medical Physics CBU, it was noted that the complaints in this CBU were mainly related to waiting times, this had been included on the risk register and the Division had been working with the CBU to resolve issues. She queried whether the Division was on target to achieve the 10% reduction in formal complaints by quarter 4 of 2012-13 – in response, it was noted that the Division was reasonably confident to do so.

The Associate Medical Director commented that the complaints relating to 'Communication/Information' could be resolved more quickly – in response, it was noted that complaints in this category mainly related to the environment of the Theatre Arrivals Area, the Division had made every effort to make the area as comfortable as possible for patients. Improved patient information leaflets had been formulated and would be sent with admission letters to patients attending this unit. The Chief Operating Officer/Chief Nurse suggested that assistance from Voluntary Support Services might prove useful in this area.

The Patient Adviser noted that the re-opened rate for complaints was 4.3% which was the lowest in comparison to the other Divisions and queried whether lessons could be learned from the Clinical Support Division. In response, the Director of Safety and Risk commented that her team reviewed re-opened complaints on a weekly basis and advised that learning might not be transferable due to the distinct nature of complaints received by this Division. It was noted that the Division had a comprehensive process/team to co-ordinate complaint responses thereby leading to a lower number of complaints being re-opened.

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

78/12/3 Cost Improvement Programme 2012-13 – Assurance re: Quality and Safety Standards

Clinical Support Divisional representatives were in attendance for this item.

Paper E detailed UHL's processes for identifying CIP schemes with potential risks to patient safety/quality of care and reporting them to Commissioners, noting the GRMC's own receipt of exception reports on any such schemes. The Director of Safety and Risk confirmed that FY2 reduction (which was not a CIP) had now been removed from this iteration of the report. The Committee Chairman queried the issues in relation to the progress in transforming transcription services project - in response, it was noted that the 'timing' of it was the issue and had been recorded as a high risk noting that some of the in-house staff had left through the VSS scheme.

In response to a query on the process for the quality assurance of the CIP risk assessments, the Divisional Head of Nursing, Clinical Support advised that the CBUs themselves discussed their CIPs and risks at their management meetings and bi-weekly TAPS CIP meeting and the Divisional Board reviewed the risk

assessments of each individual CBU on a monthly basis. All completed risk assessments were stored on SharePoint.

Responding to a query, the Director of Safety and Risk confirmed that she was confident on the robustness of the risk assessments however she noted the need for Divisions to monitor risks on a regular basis.

In discussion on the CIP schemes relating to headcount reductions in Physiotherapy and Occupational Therapy Service, it was noted that these services were subject to a MoC process and the team leader WTE levels were expected to reduce from 12.34 to 8.4.

DD,CSD

Following the departure of the Clinical Support representatives:-

(a) the Committee Chairman suggested that the Divisional Director, Clinical Support be invited to attend the next meeting to provide an update on the Divisional CIPs from a Director's point of view; **DSR**

(b) in relation to the complaints presentation, the Medical Director suggested that a standard template be provided to Divisions to present their complaints performance to the GRMC;

(c) in response to a query from the Committee Chairman - the Director of Safety and Risk advised that any 'new risks' arising from CIP schemes did not mean that the risk assessment was not undertaken appropriately but could mean that it was initially not discussed with the appropriate staff, and **MD**

(d) the Medical Director agreed to provide wording to the Chair, East Leicestershire & Rutland CCG (outside the meeting), in respect of the other recruitment strategies that had been put in place noting that the Deanery had mandated the reduction of 6.0 FY2 doctors in the Emergency Department from August 2012.

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

(B) the Divisional Director, Clinical Support be invited to attended the GRMC meeting in August 2012 to present an update from a Divisional Director point of view on the Division's CIP schemes and the ongoing process to complete quality impact assessments, monitoring arrangements and actions to mitigate any identified risks; **DD, CSD/TA**

(C) the Medical Director to provide wording for circulation outside the meeting in respect of the other recruitment strategies in place noting that the Deanery had mandated the reduction of 6.0 FY2 doctors in the Emergency Department from August 2012, and **MD**

(E) the Director of Safety and Risk to provide a standard template to Divisions to present their complaints performance to the GRMC. **DSR**

78/12/4 <u>Report from the Children's CBU Manager</u>

<u>Resolved</u> – 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.

78/12/5 <u>Clinical Audit Annual Report 2011-12</u>

The Clinical Audit Manager attended the meeting to present paper G, the clinical audit annual report for 2011-12. The report provided an update on progress made

by the team in implementing the clinical audit strategy and highlighted the achievements made and the areas where further work was required.

Ms J Wilson, Non-Executive Director sought assurance on the process in place to ensure that the outputs from clinical audits were being acted upon - in response, it was noted that Divisions had been forthcoming to embed the actions and the Clinical Audit Committee monitored this. The Clinical Audit Manager advised that a Divisional presentation to provide an update on the clinical audit work had already been scheduled for the GRMC meeting in July 2012.

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

78/12/6 CQC National Inpatient Survey Results

The Clinical Audit Manager and the Head of Nursing, Patient Experience presented paper H, the results from the National Inpatient Survey 2011. The survey was a retrospective postal questionnaire which was sent to a sample of 850 inpatients that were treated in the Trust during August 2011. A total of 492 completed surveys were returned (return rate of 60%).

Responding to a query from the Patient Adviser, it was noted that the results of the survey were published on NHS Choices website.

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

79/12 QUALITY

79/12/1 Nursing Metrics and Extended Nursing Metrics

Paper I detailed the nursing and extended nursing metrics for June 2012, noting that there was no consistent pattern behind the underperforming areas. The Chief Operating Officer/Chief Nurse advised that 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 metric reporting. Theatre Admissions Areas were now part of specialist area metrics and plans had been approved to progress a purpose built arrivals area which would improve unit efficiency, flexibility and flow. There had been a re-launch of the WHO checklist video and further training sessions were taking place in Theatres.

Ms J Wilson, Non-Executive Director suggested adding a question to the nursing metrics on whether they were displayed on the ward, which the Chief Operating Officer/Chief Nurse agreed to consider including. Responding to a query from the Director of Safety and Risk, the Chief Operating Officer/Chief Nurse advised that consideration was being given to training Health Care Assistants (HCAs) on the VITAL programme. Responding to a query from the Chief Nurse and Quality Lead, West Leicestershire CCG in respect of the time-frame of training of HCAs, it was noted that training in relation to monitoring of pressure area care and falls assessment had already commenced and additional training for Early Warning Score assessments was being considered. **COO/CN**

In response to a query from the Committee Chairman, it was noted that the slight deterioration in some indicators within the Antenatal and Postnatal areas was likely to be linked to the number of closures of the unit.

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

(B) consideration be given to including an additional question to the metrics asking whether the results were displayed on the ward. **COO/CN**

79/12/2 Month 3 Quality Finance and Performance Report

Papers J and J1 comprised the quality, finance and performance report, heat map and associated management commentary for month 3 (month ending 30 June 2012). Reflecting the GRMC's focus on quality, risk and patient safety aspects, the Chief Operating Officer/Chief Nurse highlighted the following issues by exception:-

(a) anomalies in the Imaging waiting times. Further to a process of validation, all referrals had been reviewed by senior imaging clinicians and there were no cases where clinical concerns were raised. UHL's Internal Auditors had been commissioned by the Chief Operating Officer/Chief Nurse to undertake a review of revised processes. It was noted that due to the specialist nature of Cardiac MRI, consideration was being given to alternative tests to reduce the waiting time and accept new referrals. The Associate Medical Director commented that there were time delays in the test being done and the referral being sent back to the GP;
(b) ED remained UHL's key priority, and both the Medical Director and the Chief Operating Officer/Chief Nurse continued to meet with LLR Cluster leads on this issue;
(c) 1538 patient experience surveys were returned which exceeded the Trust's target of 1484. The target was to achieve a Net Promoter Score of 61 and the Trust was currently on target;
(d) in respect of choose and book slot availability, short and long term action plans for the main specialties of concern had been developed and were on target for delivery;
(e) pressure ulcers should be rated 'green' (the 'amber' rating represented an error in the report), and
(f) the Committee Chairman reported an anecdotal MRSA case in a particular Division - the Chief Operating Officer/Chief Nurse agreed to check this. **COO/CN**

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

The 'Readmissions' indicator remained 'amber' and in further discussion on the independent readmissions audit, the Chair, East Leicestershire and Rutland CCG agreed to check and confirm the timescales for the findings to be available. **Chair, ELR CCG**

Resolved – that (A) the anecdotal report of a MRSA case in a specific Division as mentioned by the Committee Chairman be checked, and **COO/CN**

(B) the Chair, East Leicestershire and Rutland CCG to confirm when the audit findings from the independent readmissions audit would be available. **Chair, ELR CCG**

79/12/3 Report by the Chief Operating Officer and Medical Director

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.

79/12/4 Business Continuity and Emergency Planning Annual Report

The Chief Operating Officer/Chief Nurse presented paper K, a report assuring the GRMC that the Trust was compliant with the legislation and guidance in respect of emergency preparedness. Members were advised that all issues under the Civil Contingencies Act were being addressed. A programme of training, testing and

exercising was in place and the Trust was addressing any issues identified. The priorities for 2012-13 were listed in section 8 of the report. The Chief Operating Officer/Chief Nurse specifically highlighted the need to revise the pandemic influenza plan and associated documents following the recently published DoH guidance. In response to queries raised, she agreed to:- **COO/CN**

(i) raise the matter in respect of mobile network issues of a leading service provider at the LR Forum and to check if there was a need for contingency plans to be put in place for UHL, and

(ii) discuss with the Head of Operations in respect of the protocol to be put in place when there were network/accessibility issues with the electronic systems (i.e. iLAB) used in the Trust.

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

(B) the Chief Operating Officer/Chief Nurse be request to take forward the actions agreed under points (i) and (ii) above. **COO/CN**

79/12/5 Review of Nursing Acuity

The Chief Operating Officer/Chief Nurse presented paper L, a report on the recent nursing acuity review work undertaken within the Trust. In line with the nursing objective to undertake an acuity review during 2012, parallel dialogue was also underway to accrue a sum of £2m during 2012-13, to respond to the findings of the review. The review had used a triangulated approach - the AUKUH, Trust and RCN tools had all identified a deficit in ward staffing across UHL. Key areas for investment had been identified in the following CBUs: - Medicine, Cardio-Respiratory, MSK, Cancer, Women's and Children's. It was agreed to initially invest in those wards that identified a deficit of 6 or more WTE and to use professional judgement to allocate investment to these areas. A table listing the wards and the associated costings was provided in Appendix 1. In discussion, it was noted that there was confidence that the current nursing vacancies would be filled. Members noted the need to take into account staff who had been affected by the Paediatric Safe and Sustainable Review (in the event that the current decision remained unchanged) and who might not prefer to transfer to Birmingham Children's Hospital.

Members discussed at length the issues relating to inadequate capacity/resource to manage patients who required high dependency/critical care. It was noted that the current acute care bays were not set-up to HDU capacity. In discussion, the Director of Corporate and Legal Affairs suggested that a report be presented to the GRMC further to the Clinical Summit (date to be confirmed). Members noted the need for critical care issues to be urgently resolved. **COO/CN**

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

(B) the Chief Operating Officer/Chief Nurse to confirm the date of the Clinical Summit and provide a report to the GRMC further to the summit. **COO/CN /TA**

79/12/6 Quality Impact for being fined for breaching ED target

In discussion on any fines being levied on provider organisations due to clinical quality challenges, it was noted that CCGs would continue to expect delivery of CIP targets.

Resolved – that the position be noted.

79/12/7 External Maternity Services Review - Reporting Timescales

The Chief Nurse & Quality Lead, West Leicestershire CCG advised that the terms of reference for the proposed Commissioner-led review of maternity services (commissioning and provision) had been reviewed by the CCG Board. The initial meeting to take place in August 2012 and the review to commence in September 2012 was being progressed.

Resolved – that the position be noted.

79/12/8 Report by the Chief Operating Officer/Chief Nurse

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

79/12/9 Report by the Medical Director

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.

80/12 SAFETY AND RISK

80/12/1 Patient Safety Report

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

(a) the recently published "thought papers" on patient safety by the Health Foundation;
(b) scoping work had commenced to review current practices against the 5 Critical Safety Action areas in every ward to obtain baseline information. The Committee Chairman suggested that the Programme Lead be invited to attend the next meeting to provide a general progress report on the project; **DSR/TA**
(c) actions from the Learning from Experience Group - which would be shared with the QPMG;
(d) an update on the June 2012 SUIs, 1 related to a patient safety incident, 6 related to the reporting of HAPUs and 2 related to healthcare acquired infections;
(e) a deep-dive of the SUIs relating to falls would be undertaken by the patient safety team to identify any common themes;
(f) UHL's performance to date re: completing ongoing CAS alerts with an expired deadline, and **DSR**
(g) 45-day RCA performance for June 2012. It was suggested that 45-60 day RCA performance section of the report noted the exclusions (i.e. pressure ulcers etc.).

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

(B) Ms C Rudkin, 5 Critical Safety Actions Programme Lead be invited to attend the August GRMC to provide a general progress report on the 5 CSA project, and **DSR/TA**

(C) the Director of Safety and Risk to ensure that the 45-60 day RCA performance section of the report noted the exclusions (i.e. pressure ulcers etc.). **DSR**

80/12/ Safeguarding Case Reviews

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The Chief Operating Officer/Chief Nurse advised that she had nothing further to add to the update provided in June 2012 in respect of specific identified cases.

Resolved – that the position be noted.

80/12/3 Summary of the SHA Intensive Support Team (IST) Review of Pressure Ulcers and Recommendations for Practice

Paper Q detailed a summary of the findings of the SHA IST review and progress made with the recommendations.

Resolved – that paper Q be received and noted.

80/12/4 Highlight Report of high risks open longer than three years on the UHL operational risk register

Paper R outlined the risks that had been on the operational risk register for three years or above. The Director of Safety and Risk advised that risks that had been open for four years had been recently presented to the QPMG. In discussion, it was agreed that the CBU Managers should be responsible for the local management of risk and risk register entries rather than the Quality and Safety Managers. The Chief Operating Officer/Chief Nurse agreed to write to the CBU Managers to confirm this. The Committee Chairman requested that a further update be presented to the GRMC in November 2012. **COO/CN** **DSR**

Resolved – that (A) the Chief Operating Officer/Chief Nurse to write to the CBU managers to inform them that the local management of risk and risk register entries was their responsibility, and **COO/CN**

(B) a further update on the high risks open longer than three years on the UHL operational risk register be provided to the GRMC in November 2012. **DSR/TA**

81/12 ITEMS FOR INFORMATION

81/12/1 Infection Prevention Annual Report

Resolved – that the contents of paper S be noted.

82/12 MINUTES FOR INFORMATION

82/12/1 Finance and Performance Committee

Resolved – that the Minutes of the 27 June 2012 Finance and Performance Committee meeting (paper T refers) be noted for information.

83/12 ANY OTHER BUSINESS

There were no items of any other business.

84/12 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 26 July 2012 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

- Acute Care Division complaints performance data Quarter 1 -2012 -13 (Minute 78/12/1 refers);

- Discussion under Minute 78/12/4 ;
- Review of Nursing Acuity and discussion re: HDU Capacity and Clinical Summit (Minute 79/12/5 refers) ;
- Discussion under Minute 79/12/8;
- Discussion under Minute 79/12/9, and
- SHA Intensive Support Team Review of Pressure Ulcers and Recommendations for Practice (Minute 80/12/3 refers).

85/12 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Monday, 20 August 2012 from 1:30pm in the Cedar Room, Knighton Street Offices, Leicester Royal Infirmary. **TA**

The meeting closed at 4.30pm

Hina Majeed
Trust Administrator

University Hospitals of Leicester NHS Trust

Governance and Risk Management Committee

Annual Report 2011 / 12

FOREWORD

The purpose of this University Hospitals of Leicester (UHL) NHS Trust Governance and Risk Management Committee Annual Report is to provide a brief commentary on the work of the Committee in the 2011/12 financial year.

This is the first such report prepared by UHL's Governance and Risk Management Committee. I hope you find it of interest.

We would welcome feedback on this Annual Report. Please forward comments to me c/o Stephen Ward, Director of Corporate and Legal Affairs at stephen.ward@uhl-tr.nhs.uk or at: -

Leicester Royal Infirmary,
Infirmary Square,
Leicester
LE1 5WW

David Tracy
Chairman, UHL Governance and Risk Management Committee
July 2012

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The Role of the Governance and Risk Management Committee

The purpose of NHS Boards is to govern effectively and in doing so, to build patient, public and stakeholder confidence that their health and healthcare is in safe hands.

This fundamental accountability to patients, the public and stakeholders is developed by building confidence:-

- in the quality and safety of health services;
- that resources are invested in a way that delivers optimal health outcomes;
- in the accessibility and responsiveness of health services;
- that the public can appropriately shape health services to meet their needs;
- that public money is spent in a way that is efficient and effective.

The UHL Trust Board has established a committee structure to strengthen its focus on finance and performance, governance and risk management and workforce and organisational development. The structure is designed to provide effective governance over, and challenge to, the Trust's various business activities. The committees therefore carry out detailed work of assurance on behalf of the Trust Board.

Within the established framework, the distinct role of the Governance and Risk Management Committee is to provide assurance to the Board in respect of the areas of activity that affect the quality and safety of the Trust's services and, in so doing, seek to identify and quantify risks and opportunities to the Trust's improvement plans. The Committee reviews management plans to mitigate identified risks and monitors the delivery of those plans to support the Trust's delivery of the agreed objectives.

Membership and meetings

The exercise of effective oversight requires objectivity and relevant experience. These are among the attributes that Non-Executive Directors bring to the Trust Board and it is for this reason that four Non-Executive Directors have been appointed by the Board to the Governance and Risk Management Committee, namely, David Tracy, Prakash Panchal, Jane Wilson and David Wynford-Thomas.

The membership of the Governance and Risk Management Committee consists of these four Non-Executive Directors, together with the Chief Executive, Medical Director, Chief Operating Officer/Chief Nurse, Director of Corporate and Legal Affairs and Director of Communications and External Relations. The Director of Clinical Quality, Director of Nursing and Director of Safety and Risk attend too, and from time to time other Corporate Directors

and Clinical Divisional representatives attend Committee meetings to report and account to the Committee on their work.

The Committee also benefits from the contribution of Mr Martin Caple, UHL Patient Adviser, who sits as a non-voting, co-opted member. Mr Caple is able to offer great insight into the patient or service user experience at the Trust, and his co-opted membership of the Committee enriches its deliberations.

A representative of the Leicestershire, Leicester and Rutland PCT Cluster also attends each meeting of the Committee, providing the opportunity for the Trust's main Commissioners to comment upon, and satisfy themselves upon, the ways in which the Trust seeks to assure itself of the quality and safety of its services.

David Tracy is Chairman of the Committee and has held that role since late 2009.

David Tracy was a Senior Executive with Barclays Bank for 15 years. His final role prior to retirement was as Regional Corporate Director with responsibility for business banking across the Midlands.

He is also the Chairman of the Insolvency Practices Council, a national public interest body that advises the insolvency profession and its regulators on the professional and ethical standards of insolvency practitioners

Prakash Panchal is currently chief executive for the Leicestershire Ethnic Minority Partnership (LEMP), a role he has held since October 2005.

Jane Wilson has an honours degree in engineering and joined the Trust from the manufacturing sector, where she worked for almost 25 years.
Until July 2008 Jane was human resources director for the pet and food divisions of Mars in the UK. Jane's other roles include chair of Leicestershire and Rutland Probation Trust, where she led the board in successfully achieving trust status.

David Wynford-Thomas is a renowned cancer specialist who has built up a highly respected research team studying the molecular basis of cancer and its clinical applications, with long-term funding from Cancer Research UK and various prestigious institutions.

He is a pro-vice chancellor, the dean of medicine and head of the College of Medicine, Biological and Psychological Sciences at the University of Leicester.

The Governance and Risk Management Committee met on 12 occasions during 2011/12. Each meeting was quorate and attendance details are set out below.

NAME	GOVERNANCE AND RISK MANAGEMENT COMMITTEE MAXIMUM - 12
David Tracy	12
Prakash Panchal	10
Jane Wilson	9
David Wynford-Thomas	7
Kevin Harris	7
Suzanne Hinchliffe	8
Malcolm Lowe-Lauri	11
Stephen Ward	9
Mark Wightman	9
Liz Rowbotham*/Caroline Trevithick*	12
Martin Caple *	8

* non-voting member

Agenda papers are prepared and circulated in advance of meetings. The minutes of each Governance and Risk Management Committee meeting are submitted to the next available meeting of the Trust Board and are presented at Board meetings by the Committee Chairman.

Review of 2011/12

During 2011/12, the Governance and Risk Management Committee reviewed a range of activities affecting the quality and safety of services of the Trust in support of the Trust Board's actions to ensure : -

- the strategic plan is achieved;
- that financial targets are achieved;
- accountability and regulatory compliance;
- quality in service provision

and with a view to:-

- effectively assessing risk/supporting innovation;
- enhancing organisation reputation/competitiveness;
- providing confidence in organisational governance;
- constructively supporting/challenging the Board.

Specific matters considered by the Committee during the year included:-

- plans to improve the Trust's performance in relation to treating fractured neck-of-femur patients;

- measures to improve clinical involvement in clinical coding;

- the Trust's theatre modernisation programme;

- the Trust's clinical audit programme;

- measures to improve the Trust's performance in relation to venous thrombo-embolism (VTE) assessments;

- the preparation of the Trust's Quality Account 2011/12;

- the learning to be derived and applied in the delivery of clinical services arising from a number of Inquests involving the Trust held during 2011/12;

- perinatal mortality, neonatal mortality and stillbirth rates in Leicestershire, Leicester and Rutland and means of working with local partners to try to effect improvement in these rates;

- a review of the means by which Clinical Divisions assured themselves that their plans to achieve cost savings in-year did not impact adversely on the safety and quality of services;

- the results of self-assessments against the Care Quality Commission's quality and safety outcome measures;

- the lessons to be learned and applied following route cause analysis of a number of fire incidents at the Trust;

- review of the Trust's emergency planning and business continuity arrangements;

- review of the Trust's arrangements for handling and learning lessons from patient complaints;

- reviewing the implementation of an action plan relating to the Paediatric Neurology service;

- receiving the annual report of the Trust's New and Innovative Procedures Advisory Group;

- the establishment of the 'Five Critical Safety Actions' programme at the Trust;

- reviewing the measures in place at the Trust to learn from clinical negligence claims;

- reviewing the lessons to be learned and applied from complaints involving the Trust investigated by the Parliamentary and Health Service Ombudsman;

- a review of incidents of falls at the Trust, and measures to reduce the incidence of such falls;

- the Trust's mortality performance as judged by the Summary Hospital Mortality Index (SHMI); Hospital Standardised Mortality Rate (HSMR); and Risk Adjusted Mortality Index (RAMI);

- the implementation of a new electronic prescribing and medicines administrative system at the Trust;

- the review of 'quality visits' undertaken by representatives of the PCT Cluster;

- the introduction of the 'Friends and Family Test';

- reviewing the actions to be taken in response to the Care Quality Commission's findings following their unannounced inspections at the Leicester Royal Infirmary in March 2012.

During 2011/12, the Committee also continued to receive at its meetings reports assessing the Trust's position in relation to the following matters:

- nursing metrics, and the 'extended' nursing metrics;

- safeguarding reviews;

- pressure ulcers, and the Trust's plans to reduce the incidence of avoidable pressure ulcers;

- quality and safety performance, month by month, captured in the 'Quality and Performance' report;

- open 'central alerting system' alerts

and routinely received

- a patient safety report, authored by the Director of Safety and Risk, including details of Serious Untoward Incidents at the Trust;

- information reviewing the results of patient surveys undertaken at UHL, as a means of focusing attention on how the Trust should plan to improve the patient experience.

Looking Forward: 2012/13 and beyond

In 2012/13, the Governance and Risk Management Committee will continue to focus upon its core role of providing assurance to the Trust Board in respect of all areas of activity that affect the quality and safety of the Trust's services.

It is likely that the agenda of the Committee will be impacted by the contents of the second Francis Inquiry report, when published during Autumn 2012.

Adopting a horizon-scanning approach will be of particular importance during 2012/13 as the Trust takes forward its application to become an NHS Foundation Trust.

Central to the Trust's application will be the ability to demonstrate that the Trust has in place effective quality governance arrangements. The Governance and Risk Management Committee will continue to fulfil a key role in meeting this requirement.

David Tracy
Chairman, Governance and Risk Management Committee
July 2012