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: 5 April 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 23 February 2012. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 1 March 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:

- **Bed Pressure – Safety Issues (Minute 25/12/4).**

DATE OF NEXT COMMITTEE MEETING: 29 March 2012

Mr D Tracy
30 March 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON THURSDAY 23 FEBRUARY 2012 IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Mr M Caple – Patient Adviser (non voting member)
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Mr M Lowe-Lauri – Chief Executive (up to and including Minute 25/12/6)
Mr P Panchal – Non-Executive Director
Dr P Rabey – Acting Medical Director/Divisional Director, Women's and Children's
Ms C Trevithick – Associate Director of Quality/Executive Nurse, West Leicestershire and Rutland CCG (non voting member)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations (up to and including part-Minute 25/12/4)
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Ms K Bennett – PwC (Internal Audit) (observing)
Ms R Broughton – Head of Outcomes and Effectiveness (for Minute 24/12/6)
Dr B Collett – Associate Medical Director, Clinical Effectiveness (up to and including part-Minute 25/12/10)
Miss M Durbridge – Director of Safety and Risk (up to and including Minute 25/12/8)
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Ms F Newport – PwC (Internal Audit) (observing)
Ms H Poestges – Researcher, KCL (observing)
Ms N Savage – Divisional Quality and Safety Manager, Women's and Children's (for Minute 23/12/1)
Ms L Stills – Graduate Management Trainee/Strategic Planner, UHL (observing)
Ms K Wilkins – Divisional Head of Nursing, Women's and Children's (for Minute 23/12/1)

ACTION

RESOLVED ITEMS

21/12 APOLOGIES

Apologies for absence were received from Dr K Harris, Medical Director and Mrs C Ribbins, Director of Nursing/Deputy DIPAC.

22/12 MINUTES

In respect of Minute 12/12/1, the Associate Medical Director agreed to check with the Chief Pharmacist regarding the potential date for the implementation of the EPMA system in Children's Services. **AMD**

Resolved – that subject to the confirmation of the above, the Minutes (papers A-A1) from the meeting held on 26 January 2012 be confirmed as a correct record.

23/12 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 15/12/3, the Director of Safety and Risk advised that an update on reporting and handling of near-misses would be presented to the GRMC in March 2012. **DSR**

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

(B) an update on reporting and handling of near-misses be presented to the GRMC in March 2012. **DSR/TA**

23/12/1 Women's and Children's Complaints Performance Report

a. Analysis of complaints data in the context of local demographics

Further to Minute 107/11 of 25 November 2011, the Divisional Head of Nursing, Women's and Children's advised that an analysis the Women's and Children's complaints data in the context of local demographic information had been undertaken and confirmed that the complainants were proportionate with the local population. In discussion, the Divisional Director, Women's and Children's suggested that it would be appropriate for the Women's and Children's Divisional Board meetings to monitor the analysis of complaints data in the context of local demographics on a regular basis. **DD, W&C**

b. Benchmarking Data

The Divisional Quality and Safety Manager, Women's and Children's had contacted a number of Trusts (Maternity Services) to obtain data on the numbers and themes of complaints received against activity, in order to make a comparison. A limited response had been received. From the data received, members were advised that no significant variation had been noticed (it was agreed that a report would be circulated for information, outside the meeting). The most common complaint themes were 'communication' and 'staff attitude'. The Division had seen a downward trend in the number of complaints received noting that no staff attitude complaints had been received in January 2012. An online patient satisfaction questionnaire had been launched and approximately 900 completed questionnaires were received in January 2012. Responding to a query on whether there were high numbers of complaints specifically relating to the labour ward, it was noted that it would be challenging to segregate this as the whole episode of care needed to be taken into account. **Q&SM, W&C**

The Divisional Director, Women's and Children's advised that due to capacity pressures, there were occasions when one of UHL's maternity units had been unable to accept admissions for a short period of time and so admissions would be redirected to the other site. The CBU had plans to help safely manage all levels of activity with an escalation plan if admissions in one unit needed to be temporarily transferred to the other site. He highlighted that this might be one of the reasons for the complaints received and advised that appropriate communication would drive down the numbers.

Mr P Panchal, Non-Executive Director reported that some cultures might be more reluctant to make a complaint. He noted that the patient experience team had been meeting with black and ethnic minority groups to ascertain their views in respect of the patient experience survey and suggested the Women's CBU did the same. In response, it was noted that this was already being addressed through the Maternity Service Liaison Committee.

Ms J Wilson, Non-Executive Director suggested that complaints data be reported as comparison to benchmarking data on a quarterly basis. The Chief Executive agreed to liaise with the Brookfield Group to ascertain whether they would be interested in sharing information on the complaints data in order to use it as a benchmarking tool. The Patient Adviser highlighted that meetings with the Heads of Nursing and Quality Teams in the Medicine CBU and GI Medicine/Surgery/Urology CBU had been held to agree actions to reduce complaints and suggested that an update on that at the GRMC would prove useful – in response, the Director of Safety and Risk confirmed that an update on complaints management had already been scheduled for the GRMC meeting in March 2012. **CE**

The Quality and Safety Manager provided a brief update on behalf of the Head of Midwifery in respect of the analysis of the staffing structure at the Heart of England Trust. Members noted that there were slight variations to UHL's Divisional structure, however, the CBU structures were very similar.

Resolved – that (A) the analysis of complaints data in the context of local demographics be monitored by the Women's and Children's Divisional Board meetings; **DD, W&C**

(B) the benchmarking report in respect of the number of complaints received within Maternity services in other Trusts be circulated to the members of the GRMC, and **Q&SM, W&C**

(C) the Brookfield Group be contacted to ascertain if they would be interested in sharing information on the complaints data in order to use it as a benchmarking tool. **CE**

23/12/2 Update on Perinatal Mortality

Further to Minute 108/11 of 25 November 2011, the Acting Medical Director provided a verbal update on behalf of Mr I Scudamore, Consultant Obstetrician. Members were advised of the higher than average incidence of perinatal mortality amongst the population of Leicester City and that the statistics for the County had been broadly in line with the national average. The reason for the high incidence was due to the high number of still births in Leicester City's population. He also noted the need for customised foetal growth charts for at risk patients (i.e. identifying any intra-uterine growth problems at an early stage) and additional sonography resources.

The Director of Clinical Quality commented that there had been suggestions for including 'perinatal mortality' on the quality strategy dashboard but she queried whether this would be appropriate noting that there were systems in place to monitor and reduce the occurrence of perinatal mortality.

The Acting Medical Director advised that a recent visit to Maternity Centres in other Trusts had indicated that they had included additional clinic visits and scans for patients who were at risk of having small babies. These centres had developed follow-up patient care pathways relating to small-for-dates babies. In discussion, the Associate Director of Quality/Executive Nurse, West Leicestershire and Rutland CCG agreed to discuss with the CCG in respect of monitoring perinatal mortality within the wider health economy. The Chief Executive suggested that the Acting Medical Director liaised with Professor A Rashid, Medical Director, NHS LCR to provide an update on this discussion and obtain his views. **ADQ/EN, WLR CCG** **AMD**

Resolved – that (A) the Associate Director of Quality/Executive Nurse, West Leicestershire and Rutland CCG be requested to discuss with the CCG in respect of monitoring perinatal mortality within the wider health economy - use of customised foetal growth charts for at risk patients (i.e. identifying any intra-uterine growth problems at an early stage) and the need for additional sonography resources to implement this development, and **ADQ/EN, WLR CCG**

(B) the Acting Medical Director be requested to contact Professor A Rashid, Medical Director, NHS LCR to provide an update on the perinatal mortality discussion and obtain his views. **AMD**

24/12 QUALITY

24/12/1 Nursing Metrics and Extended Nursing Metrics

Paper C summarised progress against the nursing metrics for the period August 2009 - January 2012. Out of the 13 metrics in place, 10 scored 'green' and 3 'amber'. A stretch

target of 4% had been set for the 'resuscitation' metric and an 8% improvement had been noticed. Arrangements had been made for 100% monitoring of falls, pressure ulcers and VTE on designated dates as part of the SHA's requirements for the 2012 safety thermometer. Paper C1 detailed the extended nursing metrics in place within 8 specialist areas across the Trust.

Resolved – that the contents of papers C and C1 be received and noted.

24/12/2 Quality, Finance and Performance Report – Month 10

Papers D and D1 detailed the quality, finance and performance report, heat map and associated management commentary for month 10 (month ending 31 January 2012). The Chief Operating Officer/Chief Nurse highlighted following key themes from the report:-

(a) challenges remained in the delivery of the 62 day wait cancer target. The diagnostic extended pathways were being reviewed given the importance of delivery of this target. The Committee Chairman requested the patient pathway report in respect of the breach position for 2 patients relating to the delivery of the 62 day wait cancer target be circulated outside the meeting; **COO/CN**
(b) progress made in respect of the 3 patients (waiting over 52 weeks) in the General Surgery CBU – they had now received dates for treatment;
(c) a microbiology and infection prevention report had been completed in respect of one ward restriction due to influenza;
(d) in respect of patients waiting on planned waiting lists – work continued to validate patient records for inpatient, day cases and out-patients, and
(e) in discussion on the Fractured Neck of Femur performance – the bid for the Consultant Ortho-Geriatrician post had been approved.

In response to a comment from the Patient Adviser in respect of the increase in readmissions in the Planned Care Division and further discussion on planning work for the forthcoming Easter Bank Holiday, the Chief Executive advised that this was due to be discussed at the next Emergency Care Network Board and he agreed to provide an update at the GRMC meeting in March 2012. **CE**

Responding to a query from the Director of Communications and External Relations, it was noted that currently there were three wards in the Medicine CBU which were underperforming in the nursing metrics.

Resolved – that (A) the quality and performance report and divisional heat map for month 9 (month ending December 2011) be noted, and

(B) the patient pathway report in respect of the breach position for 2 patients relating to the delivery of the 62 day wait cancer target be circulated, and **COO/CN**

(C) the Emergency Care Network Board discussions in respect of ensuring adequate staffing to prevent avoidable readmissions during the Easter period be reported to the GRMC in March 2012. **CE**

24/12/3 2011-12 Quality Account (QA) – First Draft

Further to Minute 14/12/5 of 26 January 2012, paper E was a draft version of the 2011-12 quality account. The Director of Clinical Quality had outlined the QA process to LINks and requested for suggestions to be included in the report. The draft QA would be presented to the Overview and Scrutiny Committee in April 2012. The Trust's External Auditors (KPMG) had reviewed the process and would provide information on data quality.

Further to internal consultation, a list of ten priorities for 2012-13 had been circulated to LINks, Patient Advisers and other related parties who had been requested to rank the areas that they felt that UHL should focus on. The Director of Clinical Quality advised that

a variety of responses had been received and the three major priorities from this exercise were as follows:-

(a) improving patient experience;
(b) improving the use of the WHO theatre checklist, and
(c) reducing readmissions.

In respect of the above priorities, members expressed a view that priorities (b) and (c) were actually covered in priority (a) (i.e. improving patient experience). The Acting Medical Director highlighted that complying with the WHO theatre checklist was a 'standard' and noted the need for disciplinary action to be taken if was not complied with.

It was a statutory requirement to include feedback on the last year's (2010-11) priorities within this year's (2011-12) QA. Though there had been improvement in the priorities set for 2010-11, it was not as anticipated. Ms J Wilson, Non-Executive Director noted that the priorities set for 2010-11 had not been fully met and queried whether these should be continued as priorities for 2011-12. The Patient Adviser also highlighted that the targets for the priorities should be ambitious but realistic. The Director of Communications and External Relations suggested that the priorities set for 2010-11 should be continued in 2011-12 with the inclusion of 'reducing cancellations on the day of surgery for non clinical reasons'.

In further discussion, it was suggested that support be sought from the Acting Medical Director and the Director of Communications and External Relations in respect of:-

(a) inclusion of appropriate wording in respect of progress on 2010-11 quality account priorities, and **DCQ**
(b) three priorities for improvement in 2012-13 to be included in the quality account. **DCQ**

Responding to a query from the Committee Chairman, it was noted that the final quality accounts were required to be published by 30 June 2012 and hence a draft would be presented to the GRMC in March 2012 for final comments. **DCQ**

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

(B) the Director of Clinical Quality be requested to liaise with the Medical Director and the Acting Medical Director in respect of inclusion of appropriate wording in respect of progress on 2010-11 quality account priorities, and **DCQ**

(C) the Director of Clinical Quality be requested to liaise with the Director of Communications and External Relations in respect of the three priorities for improvement in 2012-13 and present a final draft of the 2011-12 Quality Account at the March 2012 GRMC meeting. **DCQ/TA**

24/12/4 <u>Quarterly Report from Clinical Audit Committee</u>

The Director of Clinical Quality introduced paper F, a progress report against UHL's clinical audit programme, noting that the clinical audit dashboard had now been provided at appendix 1 and the self-assessment undertaken by the Clinical Audit Manager was provided at appendix 2. The Trust's Internal Auditors would be evaluating the Trust's arrangements for driving clinical effectiveness and the planning and reporting of the clinical audit programme.

Members commented that the report provided details of the number of clinical audits but did not address the qualitative aspects. In response to a query on the actions taken on the audits which were rated 'red', it was noted that Divisions were expected to discuss and monitor the action plans at their Divisional/CBU meetings and flag any concerns to the Clinical Audit Committee. The Director of Corporate and Legal Affairs also voiced concerns on whether the outcome from the audits made an impact on patient care.

The Director of Clinical Quality advised that there was a section in the Quality Accounts where the Trust reported on its participation in national audits. The Acting Medical Director made members aware that the Trust undertook considerable number of audits in preparation for CNST assessments. The Associate Medical Director, Clinical Effectiveness highlighted that some of the audits had been clinically important and had significant clinical relevance.

The Committee Chairman suggested that Director of Clinical Quality liaised with the Acting Medical Director to ensure that the next quarterly Clinical Audit Committee report included details on whether the outcomes from audits had had an impact on patient care. **DCQ**

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

(B) the Director of Clinical Quality be requested to liaise with the Acting Medical Director and ensure that the next quarterly Clinical Audit Committee report included details on whether the outcomes from audits have had an impact on patient care. **DCQ/TA**

24/12/5 CQUIN Scheme Quarter 2 Reconciliation

Paper G outlined the performance for quarter 2 (2011-12) against the CQUIN scheme indicators. The Trust was being monitored on 64 indicators as part of the 2011-12 contract. The Committee Chairman queried the reason for the delay in the reconciliation process noting that the performance in quarter 2 (July – September 2011) was being reported in February 2012 – in response, it was noted that it was a time-consuming process, however, it was expected to improve as a mechanism was now being put in place for quicker analysis of reports by GP Commissioners. Quarter 3 performance would be discussed at the Clinical Quality Review Group in February 2012.

Resolved – that the position be noted.

24/12/6 Summary Hospital Mortality Index (SHMI) Report

Ms R Broughton, Head of Outcomes and Effectiveness attended the meeting to present paper H, an update on UHL's SHMI and actions being taken to ensure UHL's risk adjusted mortality accurately reflected the clinical complexity of patients admitted to the Trust. A case note review had identified a need to improve documentation of primary diagnosis and co-morbidities in order to improve accuracy of clinical coding. All Clinicians had been advise to ensure that 'working diagnosis' and 'co-morbidities' were clearly documented at the first senior ward round review. The Trust would be working with a public health Specialist Registrar to review the out of hospital deaths.

The Director of Communications and External Relations noted that the Trust had had a number of discussions on improving coding and queried whether a deadline had been set when all coding related issues would be resolved – in response, members were advised that coding was not an exact 'science' and UHL was not alone in resolving the coding related issues. The electronic encoder 'Medicode', (a software package that the clinical coders would use to assist them in recording more accurate and complex coding) had gone live in the Trust in February 2012.

Mr P Panchal, Non-Executive Director queried whether a timeline could be set to improve the accuracy of clinical coding which would in turn inform the 'case mix adjustment' within the SHMI – in response, an indicative timeline of 3 months was given. **HOE**

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

(B) the Head of Outcomes and Effectiveness be requested to provide an update report on SHMI to the GRMC meeting in June 2012. **HOE/TA**

25/12 SAFETY AND RISK

25/12/1 Electronic Prescribing

The Associate Medical Director, Clinical Effectiveness presented paper I, a progress report on the implementation of electronic prescribing and medicines administration (EPMA) system. UHL was the first Trust in the United Kingdom to implement the iSOFT EPMA product (also known as Medchart). Within UHL, Medchart had been implemented in the Bone Marrow Transplant Unit, Haematology and Oncology. Feedback from these areas had been positive and the system had aided compliance with VTE assessments.

It was highlighted that discussions were underway for an interface between the EPMA system and the Sunquest ICE system (GP ordering system used by UHL) in order to ensure that medication could be transferred directly from the EPMA prescription chart to the ICE discharge letter.

A EPMA e-learning package was being developed which would assist locum staff to undertake the training. In response to a suggestion by the Director of Communications and External Relations, it was noted that a discussion in respect of accelerating the roll-out of the EPMA system within the Trust would be held outside the meeting. There was a need for additional trainers to facilitate a more rapid but safe roll-out within Leicester Royal Infirmary initially and further to the Glenfield Hospital and Leicester General Hospital sites. Professor D Wynford-Thomas suggested that cascade training might be one of the options to quicken the training. It was noted that this was contingent on releasing staff from their clinical duties. The Chief Operating Officer/Chief Nurse suggested that consideration be given for a transformational bid for trainers to support the roll-out/cascade training of the EPMA system.

CE/COO. CN/AMD (CE)

AMD (CE)

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

(B) the acceleration of the roll-out of the EPMA system within the Trust be discussed outside the meeting, and

CE/COO/ CN/AMD (CE)

(C) a transformational bid for trainers to support the roll-out/cascade training of the EPMA system be considered.

AMD (CE)

25/12/2 Development of Medical Metrics

Paper J provided an update on the implementation of medical metrics within UHL. The Associate Medical Director, Clinical Effectiveness reported that 10 indicators around the three domains of quality (i.e. safety, effectiveness and patient experience) had been agreed by the Clinical Audit Committee. Work was now underway to incorporate these indicators into a Consultant/ward medical metrics dashboard which would be presented to the GRMC in August 2012. Members suggested the inclusion of some indicators which were agreed to be taken into consideration.

AMD (CE)

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

(B) the medical metrics dashboard be presented to the GRMC in August 2012.

AMD(CE) TA

25/12/3 Issues relating to closure of CAS alert re: 'Right Patient Right Blood'

The Acting Medical Director highlighted the following outstanding issues in respect of the CAS alert 'Right Patient Right Blood':-

- the need for an electronic blood tracking system, and
- all clinical and support staff (whose role included any aspect of blood transfusion) would be required to complete the blood transfusion training and assessment.

In order to meet the NPSA's requirements for competency based assessment, Clinical Divisions would be required to take responsibility for their respective staff to undertake completion of blood transfusion training and assessment. Discussions to progress the actions had been held with the Director of Human Resources, Medical Director and the Director of Safety and Risk and assurance in respect of closure of this alert would be provided to the GRMC in April 2012. **AMD**

<u>Resolved</u> – that (A) the verbal update be received and noted, and

(B) assurance regarding the closure of the CAS alert (Right Patient Right Blood) be provided at the GRMC meeting in April 2012. **AMD/TA**

25/12/4 <u>Patient Safety Report</u>

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

- bed pressure issues;
- General Medical Council's document 'Raising and acting on concerns about patient safety';
- Monitor's new quality governance document for Aspirant FTs in relation to the requirements to meet compliance with quality governance;
- SUIs reported in January 2012;
- CAS exception report, and
- UHL's 60 day performance regarding completed RCA reports.

Following the launch of the NHS whistle-blowing helpline by the Government, whereby any member of staff could raise a concern about patient safety 'without fear of recrimination', the GMC published a document 'Raising and acting on concerns about patient safety'. The new guidance set out the GMC's expectation that all doctors would take appropriate action to raise and act on concerns about patient care, dignity and safety.

A total of 19 SUIs had been escalated during January 2012 (3 related to patient safety incidents, 13 related to the reporting of Hospital Acquired Pressure Ulcers (Grade 3&4) and 3 related to Healthcare Acquired Infections).

Currently, three NPSA alerts had missed the deadlines, however, two of these had a timescale of closure by 5 March 2012. The alert re: 'Right Patient Right Blood' had been discussed under Minute 25/12/3 above.

There had been a slight deterioration in the 60 day RCA performance. The Director of Safety And Risk highlighted that from April 2012, there was a requirement for grade 1 RCA level 2 investigations to be completed and provided to the Lead Commissioner within 45 working days of the incident being reported.

The Director of Safety and Risk brought members' attention to the escalation of incidents reported in the Medicine CBU in mid-January 2012 and the increase in complaints, in general. Information received through a variety of sources indicated that the staffing levels for some shifts were insufficient to meet the acuity and activity of patients which had therefore significantly increased the number of incidents reported relating to staffing levels particularly in the Medicine CBU. The number of reported falls and other safety incidents had also increased within Acute Care with staff reporting particular concerns regarding patients being nursed on trolleys.

The Chief Operating Officer/Chief Nurse had raised safety concerns regarding the exceptional levels of activity with Commissioner colleagues. The risk assessment relating to 'capacity and staffing to maintain the emergency patient flow' (appended to paper K)

had been reviewed and now included 31 controls in place to mitigate the safety and quality risks. She had met with the Acting Medical Director to review the level of safety risk and consider any further controls. The Chief Operating Officer/Chief Nurse commented that the increase in incidents could not necessarily be linked to the 'right place, right time' initiative noting that this initiative had been in place since November 2011.

Responding to a query, it was noted that the reason for declaring a major internal incident in the Trust in January 2012 was due to an increase in admissions which had led to a significant number of extra capacity beds being open. Members were advised of the increase in the number of admissions of older (65 years and over) and sicker patients. The introduction of the 'right place, right time' initiative had identified a threshold of 3+3 trolleys on the two AMUs. However, the number of patients on trolleys had sometimes exceeded this agreed threshold which was due to batching of patients arriving via EMAS from bed bureau referrals. Despite having extra beds open, the Trust had still been short of the number of beds required to manage the expected admissions.

Members discussed at length regarding the actions and controls to be put in place and the need to communicate to staff that all incidents, SUIs and complaints were being appropriately reviewed and dealt with. The Chief Operating Officer/Chief Nurse would be discussing with the ECN Board regarding the potential methods for measuring the success of PCT actions to deflect ED attendances. The Trust's Internal Auditors would be undertaking a review of the ED processes.

In response to a number of queries relating to patients being transferred to UHL from other Trusts, the Chief Executive agreed 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. **CE**

The Associate Director of Quality/Executive Nurse, West Leicestershire and Rutland CCG advised that the CCG members had reviewed the risk assessments and visited the wards in order to gauge the issues and further visits were scheduled.

Responding to a query from the Patient Adviser, it was noted that a patient information leaflet had been developed which described the journey from the Emergency Department (ED) to the assessment unit and further to the base ward. Senior Nurses and Duty Managers had been requested to liaise with patients/families and apologise to them for the long-waiting period.

The Committee Chairman noted the efforts of staff in getting through the peak in admissions and keeping the service as close to normal as possible. However, he agreed to highlight the patient safety issues due to bed pressures to the Trust Board in March 2012. **GRMC Chair**

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

(B) 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 **CE**

(C) the issues re: patient safety due to bed pressures be highlighted to the Trust Board meeting on 1 March 2012. **GRMC Chair**

25/12/5 <u>Risk Management Report</u>

Paper L 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.

In discussion on risk 1 'Continued overheating of emergency care system', it was noted that a risk score of 25 would be more appropriate (current score was 20). This risk would be further discussed at the Trust Board meeting in March 2012.

Responding to a query from the Committee Chairman in respect of Divisional risk registers not being robust, the Director of Safety and Risk advised that the Trust's Internal Auditors had undertaken a deep-dive of the risk management processes and the results of their review would be presented to the GRMC in March 2012. **DSR**

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

(B) the outcomes of the Internal Auditor's review of risk management processes at UHL be presented to the GRMC on 29 March 2012. **DSR/TA**

25/12/6 Report on the recent fires

The Director of Safety and Risk advised members that during 2011 there had been three fire incidents at the Trust. Paper M provided assurance that the incidents had been fully investigated and a review had been undertaken. Although the three fires had unique aspects, all of these were initiated by patients using smoking materials (i.e. lighters or matches). Due to the fires, some members of staff had suffered from smoke inhalation and these had been reported separately under RIDDOR.

In response to a query, the Director of Safety and Risk was advised to seek views from the Director of Communications and External Relations in relation to wider circulation of the fire investigation reports. **DSR**

In discussion on the preventative measures for such incidents to re-occur, it was suggested that the Head of Estates and Facilities be invited to attend the GRMC meeting in June 2012 to provide a report on the progress with the actions put in place following the ward fires. **DSR/ HEF**

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

(B) the views of the Director of Communications and External Relations be sought in relation to wider circulation of the fire investigation reports, and **DSR**

(C) the Head of Estates and Facilities be invited to attend the GRMC meeting in June 2012 to provide a report on the progress with the actions put in place following the ward fires. **DSR/ HEF**

25/12/7 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.

25/12/8 Report by 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. **DSR**

25/12/9 Report by the Director of Corporate and Legal Affairs

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.

25/12/10 Granular Detail on the Actions to Resolve Staff Attitude Complaints

The Chief Operating Officer/Chief Nurse advised that she had met with the Medical Director and the Director of Safety and Risk to understand and address the rise in patient complaints related to staff attitude in two specific CBUs. An action plan would be developed and progressed through the Workforce and Organisational Development Committee. **COO/CN**

Resolved – that an action plan to address the rise in patient complaints related to staff attitude be developed and progressed through the Workforce and Organisational Development Committee. **COO/CN**

25/12/11 CIPs 2012-13 Safety and Quality Assurance Process

The Committee Chairman sought assurance that CIPs had been subjected to a rigorous process to assess any potential quality/safety impact and that there was a process in place for monitoring the quality and impact on safety of individual CIP schemes while they were being implemented. Further, he requested details on the actions the Trust would take when the implementation of a CIP scheme resulted in an unforeseen reduction in quality or patient safety. In response, the Chief Operating Officer/Chief Nurse advised that the CIPs were assessed by the Transformation Board and it would be appropriate for GRMC to have an update. **CE/COO/ CN**

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

(B) the 2012-13 CIPs safety and quality assurance process be scheduled on the agenda for the GRMC meeting in March 2012. **CE/COO/ CN**

25/12/12 Commissioner Safety Concerns

Resolved – that this item be scheduled on the agenda for the GRMC meeting in March 2012. **TA**

25/12/13 5 Critical Safety Actions – Appointment of a Project Manager

The Director of Corporate and Legal Affairs provided a verbal update on behalf of the Associate Medical Director, Clinical Effectiveness advising that interviews had been held for the appointment of a project manager for taking forward the Critical Safety Actions (CSA) work, however an appointment had not been made. Concern was expressed that the key performance indicators for the CSA would remain outstanding until this post was filled.

Resolved – that the position be noted.

26/12 ITEM FOR INFORMATION

26/12/1 Data Quality Performance Report

Resolved – that the data quality performance report (paper O refers) be received and noted.

27/12 MINUTES FOR INFORMATION

27/12/1 Finance and Performance Committee

Resolved – that the Minutes of the 25 January 2012 Finance and Performance Committee meeting (paper P refers) be received for information.

28/12 ANY OTHER BUSINESS

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

29/12 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 1 March 2012 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

- **Bed Pressure – Safety Issues (Minute 25/12/4), and**
- **Report by the Director of Safety and Risk (Minute 25/12/8).**

30/12 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Thursday, 29 March 2012 from 1:00pm in Conference Rooms 1A&1B, Gwendolen House, Leicester General Hospital.

The meeting closed at 4:20pm.

Hina Majeed,
Trust Administrator