Trust Board paper J

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 January 2012

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 25 November 2011. A covering sheet outlining the key issues discussed at this meeting was submitted to the Trust Board on 1 December 2011.

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:

- **Detailed review of Complaints (Minute 107/11 refers);**
- **Summary Hospital Mortality Index (Minute 109/11/5 refers), and**
- **Patients' Association report (Minute 110/11/1 refers)**

DATE OF NEXT COMMITTEE MEETING: 4 January 2012

Mr D Tracy
29 December 2011

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON FRIDAY 25 NOVEMBER 2011 AT 9AM IN CONFERENCE ROOMS 1A & 1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Committee Chair)
Mr M Caple – Patient Adviser
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Mr M Lowe-Lauri – Chief Executive
Mr P Panchal – Non-Executive Director (up to and including Minute 110/11/1)
Mrs E Rowbotham – Director of Quality, NHS LCR (non voting member)
Mr M Wightman – Director of Communications and External Relations

In Attendance:
Mrs R Broughton – Head of Outcomes and Effectiveness (for Minute 109/11/5)
Dr B Collett – Associate Medical Director, Clinical Effectiveness (on behalf of Dr K Harris, Medical Director)
Miss M Durbridge – Director of Safety and Risk (from part of Minute 107/11)
Mrs S Hotson – Director of Clinical Quality (up to and including part of Minute 111/11/1)
Ms H Poestges – Researcher, KCL (observing) (up to and including Minute 111/11/2)
Ms A Randle – Senior Safety Manager (Clinical Risk and Complaints) (for Minutes 107/11 and 111/11/1)
Mrs K Rayns – Trust Administrator
Mrs C Ribbins – Director of Nursing/Deputy DIPAC
Ms N Savage – Quality and Safety Manager, Women's and Children's Division (for Minute 107/11)
Mr I Scudamore – Consultant Obstetrician, Women's and Children's Division (for Minutes 107/11 and 108/11)
Ms E Spencer – Service Development Manager (observing)
Ms K Wilkins – Head of Nursing, Women's and Children's Division (for Minute 107/11)

ACTION

RESOLVED ITEMS

104/11 APOLOGIES

Apologies for absence were received from; Dr K Harris, Medical Director, Mr S Ward, Director of Corporate and Legal Affairs, Ms J Wilson, Non-Executive Director, and Professor D Wynford-Thomas, Non-Executive Director.

105/11 MINUTES

Resolved – that (A) the Trust Administrator be requested to amend Minute 97/11/3 to read Clinical Reported Outcomes Measures (CROMS), and

(B) subject to the above amendment, the Minutes and action sheet (papers A-A2) from the meeting held on 27 October 2011 be confirmed as a correct record.

106/11 MATTERS ARISING REPORT

The Committee Chair confirmed that the matters arising report (paper B) both highlighted the matters arising from the most recent meeting and provided an update on any outstanding GRMC matters arising since October 2009.

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

106/11/1 Quarter 2 (2011-12) Patient Experience Report (Minute 98/11)

In discussion on the matters arising report, the Director of Nursing confirmed that a meeting had now been arranged to consider the identified issues relating to medical components of the Medicine CBU.

In the absence of the Director of Corporate and Legal Affairs, the Director of Nursing also advised that a meeting had been scheduled to explore the scope for external support to review/translate patient experience statistics collected by the Trust. The Chief Executive offered his support in this area, if required.

107/11 DIVISIONAL COMPLAINTS PERFORMANCE REPORT – WOMEN'S AND CHILDREN'S

Ms K Wilkins, Divisional Head of Nursing, Ms N Savage, Quality and Safety Manager and Mr I Scudamore, Consultant Obstetrician attended the meeting from the Women's and Children's Division to present paper G which provided a review of complaints management within the Division during the period April to September 2011. During the presentation, the Head of Nursing highlighted the actions being taken to address a slight increase in the number of complaints received when compared with the same period during 2010. Members noted that these actions centred primarily around the implementation and embedding of the 10 point plan, patient experience projects and mandatory staff training in improving communications and the management of complaints. During the discussion following the presentation:-

(a) the Chief Operating Officer/Chief Nurse sought and received assurance that a process was in place to prevent small numbers of complaint response time breaches during holiday periods;
(b) the Chief Operating Officer/Chief Nurse queried the level of confidence that the target 5% reduction in the number of complaints would be achieved by March 2012. In response, the Divisional Team highlighted alternative methods for resolving potential complaints on the spot through improved communications and checking that all issues had been appropriately resolved, rather than routinely issuing a reminder of the formal complaints process;
(c) Mr P Panchal, Non-Executive Director sought a clarification of the term "deliveries only" and noted that this referred to maternity activity and excluded antenatal visits;
(d) Mr P Panchal, Non-Executive Director queried whether there was any site-based differentiation in the number of complaints received and noted in response that these were broadly commensurate with the levels of activity at each site;
(e) responding to a request by Mr P Panchal, Non-Executive Director, the Quality and Safety Manager provided an example of patient care which had resulted in complaints about poor communication. She noted that induction of labour could be an extremely long process and lack of regular updates from staff was often perceived as poor communication. To address this, staff had been advised to provide more regular feedback to patients to address their expectations in this respect;
(f) Mr P Panchal, Non-Executive Director and the Chief Executive both sought assurance that maternity complaints from black and ethnic minority patients were proportionate with the local population, noting that patients from some cultures might be more reluctant to make a complaint. The Divisional Head of Nursing confirmed that comments had been received from all cultures via the "you help us learn" comments boxes recently introduced. However, the Director of Communications and External Relations confirmed that patients' ethnicity was now routinely captured for patient complaints and he agreed to work with the Head of Nursing to analyse the Women's and Children's complaints data in the context of local demographic information; **DCER/ DHoN**
(g) Mr M Caple, Patient Adviser, queried whether complaints trends were narrowed down to particular individuals. The Quality and Safety Manager confirmed that no such trends involving individual members of staff had been found, although feedback was routinely provided to staff when they were named within a complaint. Targeted complaints management support had been provided to some key areas

where the levels of complaints had been higher than expected;

(h) Mrs E Rowbotham, Director of Quality, NHS LCR thanked the presentation team for this comprehensive report. She noted the significant reduction in Women's complaints between quarter 1 and quarter 2 (from 98 to 61) and queried whether any benchmarking work was being undertaken with other Trusts. The Quality and Safety Manager advised that no formal complaints benchmarking was currently carried out but she agreed to take this action forward; **QSM**

(i) the Senior Safety Manager (Clinical Risk and Complaints) confirmed that there were no concerns regarding the complaints handling process within the Division, although the number of complaints received continued to cause anxiety. Further opportunities were being explored to increase clinical engagement in the management of complaints with a view to resolving identified issues within 24 hours. She informed the GRMC that 4% of UHL's complaints were currently referred to the Ombudsman, whereas the figure for a comparable Trust currently stood at 11%;

(j) the Director of Safety and Risk noted some adverse publicity attracted through the NHS Choices website and queried whether there was any scope to hold additional open days to allay patients' concerns regarding the maternity care environment. In response, the Consultant Obstetrician and the Divisional Head of Nursing identified potential improvements in capacity, staffing ratios and patients' perception of mixed sex accommodation which they felt would improve patients' perception of UHL's services;

(k) the Committee Chairman queried the scope to resolve more of patients' concerns prior to the formal complaints process and queried whether meetings were routinely offered to all complainants. In response, the Senior Safety Manager (Clinical Risk and Complaints) noted that recent guidance had been issued to advised that meetings would only be offered where there was a genuine need and that the complaints team would assess this on a case by case basis. The Chief Operating Officer/Chief Nurse expressed her view that the opportunity for an early meeting with an unsettled family or patient was valuable within the complaints process. The Senior Safety Manager (Clinical Risk and Complaints) confirmed that meetings would still be offered where this was expected to add real value to the process, and

(l) the Committee Chairman queried whether there was any scope to resolve more complaints over the telephone and noted in response that some patients expressed a preference to receive complaints responses by email or telephone and that this was complied with wherever possible. The Consultant Obstetrician suggested that this approach was more suitable for simple issues, such as a cancelled clinic appointment, but that more complex issues required careful handling and a written response was considered more appropriate.

<u>Resolved</u> – that (A) the presentation by the Women's and Children's Division (paper G refers) be received and noted;

(B) the Director of Communications and External Relations be requested to work with the Divisional Head of Nursing to analyse complaints data in the context of local demographics and provide an update to the Governance and Risk Management Committee on 4 January 2012, and **DCER/ DHoN/ TA**

(C) the Quality and Safety Manager be requested to carry out formal benchmarking with other Trusts in respect of the number of complaints received within Women's and Children's services and provide an update to the Governance and Risk Management Committee on 23 February 2012. **QSM/TA**

108/11 UPDATE ON PERINATAL MORTALITY

Further to Minute 40/11/1 of 26 May 2011, Mr I Scudamore, Consultant Obstetrician attended the meeting to provide an update in respect of reducing the occurrence of perinatal mortality. He reminded GRMC members that statistics had previously indicated a 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 Consultant Obstetrician provided feedback from his recent visits to Trusts in Coventry and Birmingham where he had reviewed aspects of their governance structures, reporting mechanisms, rates of registration of births before 24 weeks, policies, criteria used for live births, staffing ratios and local patient demographics. GRMC members particularly noted the following observations regarding the practice at other Trusts which might contribute towards improved performance at UHL:-

(a) use of customised foetal growth charts for at risk patients. These required data to be mapped from 2 additional scans carried out within the third trimester of pregnancy to identify any intra-uterine growth problems at an early stage and additional sonography resources would be required to implement this development;
(b) intra-uterine growth impairment statistics were reported on Trusts' performance dashboards;
(c) medical reviews of each individual still birth were carried out within 48 hours and all cases were reviewed at a MDT meeting on a monthly basis;
(d) a more comprehensive staffing structure had been noted at the Heart of England Trust in Birmingham, although one particular Consultant had made significant progress with data collection and this was not considered sustainable. The Head of Midwifery had been requested to explore this staffing structure further, and **HoM**
(e) a target to reduce intra-uterine growth impairment had been established and a CQUIN for the diagnosis of this condition had been a key driver for this.

The Consultant Obstetrician had been encouraged by his recent visits to other Trusts and felt that there were opportunities for UHL to develop similar mechanisms in order to strive to reduce the incidence of perinatal mortality. He was currently seeking to update UHL's data analysis to combine this with the data provided by the University of Leicester and Public Health statistics. During the discussion on this item, members:-

(1) queried whether there was any scope to seek additional research funding to support improvements in perinatal mortality rates. The Chief Executive noted some of the challenges associated with this suggestion;
(2) noted the opportunities to develop follow-up patient care pathways relating to small-for-dates babies and the scope to time their deliveries more appropriately;
(3) considered the current resourcing issues surrounding the sonography service, including recruitment difficulties, extended scanning duration and a national tariff issue. It was agreed that the Consultant Obstetrician would work with the CBU to develop project proposals for expanding UHL's current sonography capacity, and **IS, CO/ CBU Lead**
(4) agreed that the Chief Executive would contact the Divisional Director, Women's and Children's to explore any opportunities to develop a trial study and evaluation of a process to identify and measure intra-uterine growth problems. **CE/DD, W&C**

<u>Resolved</u> – that (A) the verbal update by the Consultant Obstetrician on perinatal mortality be received and noted;

(B) the Head of Midwifery be requested to undertake a follow-up analysis of the staffing structure at the Heart of England Trust; **HoM**

(C) the Consultant Obstetrician be requested to work with the Women's CBU to develop project proposals for expanding UHL's current sonography capacity, and **IS, CO/ CBU Lead**

(D) the Chief Executive be requested to contact the Divisional Director, Women's and Children's with a view to discussing a potential trial study and evaluation in respect of identifying and measuring intra-uterine growth problems and an update be provided to the Governance and Risk Management Committee on 23 February 2012. **CE/DD, W&C/TA**

109/11 QUALITY

109/11/1 <u>Nursing Metrics and Extended Nursing Metrics</u>

The Director of Nursing introduced paper C, a summary of extending nursing metrics and comparative data for specialist areas relating to specific risk areas within the clinical environment. Responding to a query raised by Mrs E Rowbotham, Director of Quality, NHS LCR, the Director of Nursing advised that the Trust's compliance with the World Health Organisation (WHO) theatre checklist was captured within the patient observations section of the theatre metrics.

The Chief Operating Officer/Chief Nurse introduced paper C1, which provided a summary of progress against the nursing metrics between August 2009 and October 2011. She advised GRMC members that all under-performing areas (below the threshold of 80%) had submitted appropriate action plans and received visits as part of the Non-Executive Director walkabouts. Each of these areas had subsequently been re-audited and achieved results between 95% and 100% compliant.

The Chief Operating Officer/Chief Nurse briefed members on changes to the discharge metrics to improve patient flows through the Emergency Department (ED). Mr P Panchal, Non-Executive Director commented upon the insight that out-of-hours walkabouts in the ED had given him into the emergency care system and he queried the scope to increase stakeholder awareness of the pressures on the system through such visits. The Chief Operating Officer/Chief Nurse confirmed that a number of key stakeholders including GPs and CCG leads had already made such visits and the Director of Quality, NHS LCR advised that all urgent and emergency care leads would be visiting UHL's facilities over the coming weeks.

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

109/11/2 Quality, Finance and Performance Report – Month 7

Paper D detailed the quality, finance and performance report, heat map and associated management commentary for month 7 (month ending 31 October 2011). The Chief Operating Officer/Chief Nurse highlighted key themes from the report and responded to a number of queries as follows:-

(a) in accordance with recommendations made by KPMG, a more specific summary of key points had been provided at the front of the report;
(b) the process for capturing and validating patient falls data was currently under review and this section would be updated prior to the 1 December 2011 Trust Board meeting;
(c) an example of the Divisional weekly metrics reporting template was included at appendix 1. This reporting template provided an opportunity for Divisions to highlight any concerns relating to patient safety or staffing issues and to date no staffing issues had been identified which had impacted upon patient safety;
(d) new ED patient flows processes had been implemented on 21 November 2011 and assurance was provided that appropriate escalation processes were in place to report any issues or concerns as they arose;
(e) additional monitoring was being undertaken to assess the length of any patient delays in leaving UHL's discharge lounges and additional discharge lounge accommodation was being explored to expand capacity;
(f) the Chief Executive suggested that the GRMC might wish to consider requesting the CASE team to undertake some enhanced monitoring of patient mortality rates between the ED and Medicine CBUs (for assurance purposes). The Chief Operating Officer/Chief Nurse agreed to contact the Head of Outcomes and Effectiveness to discuss this suggestion; **COO/CN**
(g) the Committee Chairman noted from page 4 of the commentary report that performance relating to operations cancelled on or after the day of admission currently stood at 1.7% against the target of 0.8% and was RAG rated as red. The Chief Operating Officer/Chief Nurse briefed members on the impact of emergency activity management and additional trauma cases (including spinal surgery and neck of femur surgery) upon elective general surgery. In addition, bed capacity had

been reduced during October due to routine estates work on the nurse call system and prevention of legionella, and

(h) a further piece of work was being undertaken by Ms T Pender, the lead for the Clinical Coding Project, to scope the correlation of cancelled operations between the Planned Care and Clinical Support Divisions and an appropriate escalation process was being developed to be followed prior to cancellations. It was noted that a report on this workstream would be provided to the GRMC in January 2012. **COO/CN**

Resolved – that (A) the quality and performance report and divisional heat map for month 7 (month ending 31 October 2011) be noted;

(B) the Chief Operating Officer/Chief Nurse be requested to contact the Head of Outcomes and Effectiveness to arrange for additional assurance to be provided through enhanced monitoring of patient mortality rates between ED and Medicine CBUs and an update be provided to the GRMC on 4 January 2012, and **COO/ CN/TA**

(C) the Chief Operating Officer/Chief Nurse be requested to report to the GRMC on 4 January 2012 in respect of actions to reduce the number of operations cancelled on or after the day of surgery. **COO/CN/ TA**

109/11/3 Memorandum of Understanding for Emergency Planning between UHL and other East Midlands Trusts

The Chief Operating Officer/Chief Nurse provided assurance that the above Memorandum of Understanding had now been signed off and circulated to all relevant parties.

Resolved – that the position be noted.

109/11/4 Clinical Audit Quarterly Report

The Director of Clinical Quality introduced paper E, 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. She advised that feedback on the internal audit review of outstanding actions would be presented to the next meeting of the Audit Committee on 14 February 2012. **DCQ**

The Committee Chairman queried the level to which this progress report helped to improve GRMC members' understanding of the role of clinical audit and whether it provided the required assurance that progress was on track. In response, the Director of Clinical Audit commented upon governance issues and the level of participation in mandatory audits. Arrangements for monitoring action plans more closely were being developed as part of the next phase of this workstream and a risk assessment process was being implemented to flag any concerns. Members also noted the Clinical Audit Committee reporting route through to the Clinical Effectiveness Committee.

The Director of Communications and External Relations advised that the recently announced Operating Framework for 2012-13 would place more emphasis on clinical audit to demonstrate the translation of quality themes. The Director of Clinical Quality noted that the Quality Account reporting mechanism and national quality dashboards would also be instrumental in demonstrating improvements made in respect of patient quality.

The Committee Chairman welcomed an invitation to attend a meeting of the Clinical Audit Committee and the Director of Clinical Quality agreed to provide him with the dates of the next few meetings. The Chief Executive suggested that a Trust Board development session to explore the strategic balance between research and audit might also be helpful. He undertook to meet with the Medical Director and the Chief Operating Officer/Chief **DCQ/ CHAIR**

Nurse to consider this option further alongside a process to strengthen the links between quality governance and the integrated business planning process. **CE/MD/ COO/CN**

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

(B) the Director of Clinical Quality be requested to provide the Committee Chairman with the meeting dates for the Clinical Audit Committee, and **DCQ/ CHAIR**

(C) the Chief Executive be requested to meet with the Medical Director and the Chief Operating Officer/Chief Nurse to explore the possibility of arranging a Trust Board development session on clinical audit and quality governance and an update be provided to the Governance and Risk Management Committee on 26 January 2012. **CE/MD/ COO/CN/ TA**

109/11/5 <u>Summary Hospital Mortality Index (SHMI) Report</u>

The Head of Outcomes and Effectiveness attended the meeting to introduce paper F, which provided a comprehensive briefing on SHMI – the new nationally agreed mortality indicator methodology. Members noted that SHMI indicators had been published for all Trusts on 27 October 2011 and that UHL's SHMI had stood at 106, which fell within the expected range when using the 95% control limits but was 'higher than expected' when using more sensitive 99.8% control limits. Appendix 1 to paper F provided a helpful summary of the main differences between the methodologies for calculating the following mortality indicators:-

- Summary Hospital Mortality Index (SHMI);
- Hospital Standardised Mortality Rate (HSMR), and
- Risk Adjusted Mortality Index (RAMI).

The Head of Outcomes and Effectiveness reported on further work being undertaken to improve understanding of the impact of out of hospital deaths within 30 days of discharge, a lack of exclusion for palliative care provision, co-morbidity scoring and coding by primary diagnosis instead of HRG codes. The NHS Confederation had recommended that Trusts with a higher than expected SHMI review particular aspects of their clinical care, end of life pathways and data capture mechanisms.

The Director of Quality, NHS LCR noted that SHMI was clearly stated as the indicator of choice within the Operating Framework 2012-13 and queried how frequently performance would be monitored. In response the Head of Outcomes and Effectiveness advised that performance would be monitored on a quarterly basis, six months in arrears. The Chief Executive confirmed that negotiations were currently underway with a view to purchasing the Dr Fosters Intelligence "Real Time Monitoring" tool as this system would be more effective at predicting the Trust's performance.

The Chief Operating Officer/Chief Nurse noted that the Dr Fosters Good Hospital Guide was due to be published during the following week and that UHL was also likely to feature as an outlier in respect of the number of cancelled operations due to patient notes not being available. This had been considered as a "home goal" as in 50% of cases the notes had been available on the ward and a response had been provided to Dr Fosters accordingly.

Discussion took place regarding UHL's SHMI data and the reputational risks and likely impact on the public perception of patient safety at UHL. It was agreed that the Medical Director, Associate Medical Director for Clinical Effectiveness and the Head of Outcomes and Effectiveness would be requested to develop change plans and identify clear timescales for urgent implementation. Members noted that improvements to clinical coding would be key, as would developing an understanding of any real clinical issues highlighted by the data. Liaison would also be required with Public Health and primary care to monitor the impact of palliative care in the Community upon UHL's performance. It **MD/AMD /HOE**

was agreed that a progress report on change plans would be presented to the GRMC on 4 January 2012. **MD/HOE**

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

(B) the Medical Director, Associate Medical Director for Clinical Effectiveness and the Head of Outcomes and Effectiveness be requested to develop change plans with clear timescales for improving UHL's SHMI performance, and **MD/AMD /HOE**

(C) an update on progress be reported to the GRMC on 4 January 2012. **MD/HOE**

109/11/6 Monitoring Medical Metrics – Contact with Other Trusts

The Associate Medical Director, Clinical Effectiveness reported verbally regarding her contact with Addenbrooke's Hospital noting that she had ascertained that they produced measurements of productivity, rather than medical metrics. Following further discussion with Medical representatives, some outline medical metrics had been presented to the Clinical Audit Committee, but it was agreed that several separate work strands would require pulling together into one cohesive report. Discussion took place regarding the ability to devolve medical metrics down to individual Consultant level and how meaningful the data would be if this was not possible. **AMD**

The Director of Communications and External Relations suggested reviewing practice in the USA where systems had been developed which could be interrogated at individual Consultant level. The Chief Executive noted that the Cleveland Clinic had developed some sophisticated performance management measures. The Chief Operating Officer/Chief Nurse recommended that medical metrics be based upon the practical essentials of care in the first instance (eg writing up TTOs, hand hygiene and clinic/discharge letter performance) prior to the development of more complex metrics. **AMD**

The Committee Chairman requested that the Associate Medical Director, Clinical Effectiveness provided a further report on the development of appropriate medical metrics at UHL in February 2012. **AMD**

Resolved – that (A) the verbal report on medical metrics provided by the Associate Medical Director, Clinical Effectiveness be received and noted;

(B) the Associate Medical Director, Clinical Effectiveness be requested to explore the medical metrics used in the USA (including the Cleveland Clinic), and **AMD**

(C) the Associate Medical Director, Clinical Effectiveness be requested to provide a further report on the development of appropriate medical metrics at UHL in February 2012. **AMD**

110/11 PATIENT EXPERIENCE

110/11/1 Patients' Association Report

The Director of Nursing provided a verbal report on a Glenfield Hospital patient story which had featured in the Patients' Association report "We've been listening, have you been learning?" released on 9 November 2011. This patient had been admitted to Glenfield Hospital initially for active treatment, but it had soon become apparent that end of life care was more appropriate and she was transferred to the Liverpool care pathway.

Learning outcomes surrounding pain management, communications processes, compliance with patients' wishes regarding dying at home and earlier intervention by senior medical staff had been identified. A full internal nursing and medical review was underway with specialist support being provided by LOROS. Mrs E Rowbotham, Director of Quality, NHS LCR advised that primary care input would also be provided within the

review process to address the GP input and how to address patient and carer expectations more appropriately.

The Committee Chairman requested that a wide-ranging end-to-end report on the review of this complaint (including primary care considerations), be presented to the GRMC at the earliest opportunity. The Director of Nursing noted that a report on the internal review had been provisionally scheduled for the 4 January 2011 meeting, but she suggested that this be deferred until the comprehensive report was finalised. **DoN/ DQ, NHS LCR**

The patient's family had been contacted and they were currently considering whether a meeting would be helpful in this case. The Committee Chairman queried whether there was any scope to invite the family to attend a Trust Board meeting, as part of the programme for the Board to receive regular patient story updates. It was agreed that the Director of Communications and External Relations would meet with the Medical Director and the Director of Nursing to consider this suggestion once the finalised report was available. **DCER/ MD/DoN**

<u>Resolved</u> – that (A) the verbal report provided by the Director of Nursing in respect of the Glenfield Hospital case study featured in the Patients' Association report be received and noted;

(B) the Director of Quality, NHS LCR and the Director of Nursing be requested to develop joint action plans between UHL and NHS LCR to address the concerns raised in the above case study; **DoN/ DoQ, NHS LCR**

(C) the Director of Nursing and the Medical Director be requested to meet with the patient's family (if appropriate) and consider inviting the family to attend a Trust Board meeting as part of a future patient story presentation; **DoN/MD**

(C) a comprehensive briefing paper be presented to the GRMC on 26 January 2012 outlining the full range of issues highlighted by the case study together with the UHL/LLR plans to address them. **DoN/TA**

111/11 SAFETY AND RISK

111/11/1 <u>Patient Safety Report</u>

The Director of Safety and Risk introduced the Patient Safety Report (paper H) incorporating complaints, incidents, claims and inquests data for quarter 2 (July to September 2011). A table of complaints benchmarking data was provided in section 3 of the report, as previously requested by the Committee Chairman. Section 4 provided feedback from the Internal Audit root cause analysis review and a copy of the full report was provided at appendix 2. Members noted that actions and timescales had been developed to respond to the review and these would be presented to the Audit Committee on 14 February 2012. **DSR**

In discussion on the report, the GRMC considered:-

(a) proposals to develop CBU level targets for improving complaints performance, implementing processes to resolve patient concerns prior to the formal complaints stage and developing local patient experience groups. The Chief Executive cautioned against setting cross-Trust targets and suggested a focused approach in key areas (eg Medicine or GI Medicine, Surgery and Urology) and then rolling out the arrangements once it had been determined which actions were most effective;
(b) a suggestion made by the Patient Adviser to consider patient experience exit interviews for patients leaving hospital whilst events were still fresh in their minds;
(c) opportunities to involve Matrons and Service Managers in the resolution process at an earlier stage;
(d) a proposal to develop a set of minimum organisational standards for responding to

enquiries and requests within a reasonable timescale. The Chief Executive undertook to meet with the Chief Operating Officer/Chief Nurse and the Director of Human Resources in this respect; **CE/ COO/CN**

(e) the Director of Communications and External Relations suggested that a small task and finish group be established to develop proposals for a focused approach on improving complaints performance within key areas. The Chief Executive and the Chief Operating Officer/Chief Nurse agreed to explore this option, including the scope for any Patient Adviser representation and noting an expression of interest in this role received from Mr M Caple, Patient Adviser; **CE/ COO/CN**

(f) opportunities to increase the amount of telephone contact to follow-up complaints responses to check whether all relevant issues had been appropriately addressed, and

(g) alternative methods of capturing certain categories of complaints data differently (as used by other Trusts). The Director of Safety and Risk undertook to explore such opportunities further. **DSR**

Section 5 of paper H provided a breakdown of serious untoward incident reports received in October 2011 and particular discussion took place regarding two ten times medication errors, neither of which had resulted in any patient harm, noting that there had not been any common underlying themes. The Medical Director and the Chief Pharmacist were actively reviewing all ten times medication errors and the Director of Safety and Risk noted that she had scheduled a meeting with the Divisional Director, Women's and Children's to review the incident involving the Children's CBU. The Committee Chairman requested the Medical Director to consider undertaking a "deep dive" relating to ten times medication errors in the event of any further incidents. **MD**

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

(B) the Chief Executive be requested to meet with the Chief Operating Officer/Chief Nurse and the Director of Human Resources to develop a set of organisational standards for responding to enquiries/requests within a reasonable timescale and an update be provided to the Governance and Risk Management Committee on 23 February 2012; **CE/ COO/CN/ TA**

(C) the Chief Executive and the Chief Operating Officer/Chief Nurse to explore opportunities to establish a task and finish group to address improvements in complaints performance within one or two targeted CBUs (including the scope for Patient Adviser involvement) and an update be presented to the GRMC on 26 January 2012; **CE/ COO/CN**

(D) the Director of Safety and Risk be requested to explore alternative methods to capture categories of complaints data in other ways (as used by other Trusts) and an update be provided to the GRMC on 26 January 2012, and **DSR/TA**

(E) the Medical Director be requested to meet with the Chief Pharmacist and Divisional Director, Women's and Children's Division to review two reported SUIs relating to 10 x medication errors and consider a "deep dive" in the event of further incidents and an update be provided to the GRMC on 26 January 2012. **MD/CP/ DD, W&C/TA**

111/11/2 <u>Report by the Associate Medical Director</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.

111/11/3 <u>Risk Register Report</u>

Paper I provided the 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 Director of Safety and Risk highlighted key movements within the risk register, confirming that the Acute Care Division's risk relating to staffing and skill mix had been closed due to assurance received. The scoring of the risk surrounding availability of portable suction had increased although new equipment had now been delivered and this risk would be removed once the equipment had been distributed and staff training completed. In discussion on this item:-

(a) the Committee Chairman noted that the scoring for risk 8 (deteriorating patient experience) had now been remarked, and

(b) the Director of Quality, NHS LCR queried whether the Specialised Commissioners had been made aware of delays in recruiting a Service Improvement Project Manager for the Teenage and Young Adults Service. In response, the Chief Operating Officer/Chief Nurse advised that the post had been approved for internal recruitment/redeployment in the first instance but she agreed to check the latest position with the CBU. **COO/CN**

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

(B) the Chief Operating Officer/Chief Nurse be requested to review the status of recruitment plans for a Service Improvement Project Manager for the Teenage and Young Adults Service and advise the East Midlands Specialised Commissioners accordingly and an update be provided to the GRMC on 4 January 2012. **COO/CN/ TA**

111/11/4 <u>NHSLA/CNST Accreditation Update, Analysis of Process and CNST Levels of other Comparable Trusts</u>

Additional paper 1 provided an update on the process towards UHL's NHSLA accreditation at level 1 and considered the feasibility of progressing to a level 2 assessment at the end of December 2012, subject to feedback received from the level 1 assessment.

Immediate implementation of new policies and processes would be required in order to accrue 12 months' of evidence that these policies and procedures had been implemented and embedded across the Trust.

It was agreed that the Chief Operating Officer/Chief Nurse, Medical Director and Director of Safety and Risk would be reviewing the scope to improve NHSLA accreditation processes and a further report would be provided to the GRMC on 4 January 2012. **COO/CN/ MD/DSR**

<u>Resolved</u> – that (A) the contents of additional paper 1 be received and noted;

(B) the Director of Safety and Risk be requested to assess UHL's capability to progress to NHSLA Level 2 following the Level 1 inspection in December 2011; **DSR**

(C) the Chief Operating Officer/Chief Nurse, Medical Director and the Director of Safety and Risk to scope the development of alternative processes to secure NHSLA and CNST accreditation in future years, and **COO/CN/ MD/DSR**

(D) a report on proposals to be presented to the GRMC on 4 January 2012. **MD/DSR**

111/11/5 <u>Progress relating to One Critical Safety Action</u>

Further to Minute 96/11/2 of 27 October 2011, the Associate Medical Director provided a verbal update on the work in progress in respect of the remaining two critical safety actions which were scheduled to be presented to the GRMC in January 2012 and February 2012 (respectively). The Director of Quality, NHS LCR recognised the good work that was progressing but voiced some concern regarding a potential lack of traction in implementing the improvements and monitoring success accordingly. The Committee Chairman requested that the Medical Director and Associate Medical Director provide a

concise progress report on all five critical safety actions to the GRMC on 4 January 2011 (to include the arrangements for tracking improvements). **MD/AMD**

Resolved – that the Associate Medical Director be requested to present progress update on 1 specific critical safety action and a summary of all 5 Critical Safety actions to the GRMC on 4 January 2012. **AMD/TA**

111/11/6 Report by the Director of Nursing

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

112/11 ITEMS FOR INFORMATION

112/11/1 Data Quality Report

Resolved – that the Data Quality Report (paper J refers) be received and noted.

112/11/2 Update on Clinical Coding

Resolved – that the update on Clinical Coding (paper K refers) be received and noted.

112/11/3 Six Lives Update

Resolved – that the Six Lives Update (paper L refers) be received and noted.

113/11 MINUTES FOR INFORMATION

113/11/1 Finance and Performance Committee

Resolved – that the Minutes of the 27 October 2011 Finance and Performance Committee meeting (paper M refers) be received for information.

114/11 ANY OTHER BUSINESS

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

115/11 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 December 2011 Trust Board and highlighted accordingly within these Minutes:- **GRMC CHAIR**

- **Detailed review of Complaints (Minute 107/11 refers);**
- **Summary Hospital Mortality Index (Minute 109/11/5 refers), and**
- **Patients' Association report (Minute 110/11/1 refers)**

116/11 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Wednesday, 4 January 2012 from 1:00pm in Conference Rooms 1A & 1B, Gwendolen House, LGH site.

The meeting closed at 12.15pm

Kate Rayns,
Trust Administrator