University Hospitals of Leicester NHS
NHS Trust

Paper M

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 4 March 2010

COMMITTEE: Governance and Risk Management Committee

CHAIRMAN: Mr D Tracy , Non – Executive Director

DATE OF COMMITTEE MEETING: 9 February 2010

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

The Trust Board be requested to note discussions in respect of the:-

- **Cancer Services and Haematology Presentation and associated papers (Minute 17/10/1 refers), and**
- **Improving Safe Medication Practices across UHL (Minute 17/10/2 refers)**

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

There were no key issues for consideration by the Trust Board from the Governance and Risk Management Committee.

DATE OF NEXT COMMITTEE MEETING: 9 March 2010

Mr D Tracy
26 February 2010

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE GOVERNANCE AND RISK MANAGEMENT COMMITTEE HELD ON TUESDAY 9 FEBRUARY 2010 AT 8.30AM IN CONFERENCE ROOMS 1A & 1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr D Tracy – Non-Executive Director (Chairman)
Mr K Harris – Acting Medical Director
Mrs S Hinchliffe – Chief Operating Officer / Chief Nurse
Mr M Lowe-Lauri - Chief Executive
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs S Khalid – Chief Pharmacist (for Minute 17/10/2)
Mr M Nattrass – General Manager, Cancer Services and Haematology (for Minute 17/10/1)
Ms Jane Pickard – Head of Nursing, Cancer Centre Lead Nurse (for Minute 17/10/1)
Dr N Rudd – Clinical Director, Cancer Services and Haematology (for Minute 17/10/1)
Mrs E Ryan – General Manager, Musculo-Skeletal Services (for Minute 16/10/1)
Ms M Wain – Clinical Governance Lead, Cancer Services and Haematology (for Minute 17/10/1)
Mr A Whalley – Temporary Trust Administrator

RESOLVED ITEMS **ACTION**

14/10 APOLOGIES

Apologies for absence were received from Mr M Caple, Patient Advisor and Mrs E Rowbotham, Director of Quality, NHS Leicestershire County and Rutland.

15/10 MINUTES OF THE PREVIOUS MEETING

In respect of Minute 05/10/3 (Patient Safety Report) it was agreed that the Director of Safety and Risk be requested to update Trust Administration with an amendment to item 05/10/3 of the Minutes of the Governance and Risk Management Committee meeting held on 12 January 2010. **DSR/ TA**

Resolved – that (A) the Trust Administrator be requested to make the amendment outlined above to the Minutes of the previous meeting held on 12 January 2010, and **TA**

(B) the contents of the associated Governance and Risk Management Committee action sheet from the same meeting (paper A1) be received and noted.

16/10 MATTERS ARISING FROM THE MINUTES

16/10/1 Patient Safety Report (Minute 04/10/1)

The General Manager, Musculo-Skeletal Services presented paper B which provided an analysis of the themes and trends in formal and verbal complaints received within Musculo-Skeletal Services in the first three quarters 2009/10. She advised that the complaints for each speciality had been broken down by Primary subject and each

complaint had been reviewed to identify the detail of the subject matter. Actions plans by specialty had been devised and references were made to them as part of the paper. As an example, Members were requested to note that the majority of the action plan for Rheumatology had been written and implemented in September 2009 and this has been evidenced by the reduction in complaints in November and December 2009. The General Manager, Musculo-Skeletal Services informed the Members that she had set time aside to enable a regular review of the action plans and, in particular, that the action plans for recording of complaints had been reviewed weekly by the Clinical Governance Manager.

Resolved – that the contents of this presentation and associated documentation be received and noted.

16/10/2 Directorate Risk Registers (Minute 04/10/2)

The Director of Safety and Risk advised that all Directorate Risk Registers were currently being reviewed by the Risk and Assurance Manager and the Director of Safety and Risk. All risks with a score over 20 and all risks that had been on the Register for over one year had been subject to confirmation and challenge. Clinical Directors and General Managers had been further requested to provide a detailed risk assessment in relation to *achieving* their Cost Improvement Plan. The Trust Executive at its meeting on 27 January 2010 (Minute 06/10/1 refers) had asked the Director of Safety and Risk to identify risk themes and actions in a future report to the Trust Executive on a date to be fixed and, to the meeting of the Governance and Risk Management Committee on 9 March 2010 and each subsequent meeting, to select a sample risk from the Risk Registers and to present this within the assurance framework in place for the Committee to assess the sufficiency of that framework. **DSR** **CDs/ GMs** **DSR/ TA**

Resolved – that (A) the Director of Safety and Risk be requested with the Risk and Assurance Manager to review all Directorate Risk Registers, **DSR/ TA**

(B) Clinical Directors and General Managers be requested to provide a detailed risk assessment in relation to achieving their respective Cost Improvement Plans, **CDs/ GMs**

(C) the Director of Safety and Risk be requested to identify risk themes and actions in a future report to the Trust Executive on a date to be fixed, and **DSR/ TA**

(D) the Director of Safety and Risk be requested to present to the meeting of the Governance and Risk Management Committee on 9 March 2010 and each subsequent meeting, a sample risk from the Risk Registers and to present this within the assurance framework in place for the Committee to assess the sufficiency of that framework. **DSR/ TA**

16/10/3 Care Quality Commission (CQC) Registration (Minute 04/10/3)

The Director of Clinical Quality presented paper C and confirmed that the application for registration with the CQC had been submitted on 28 January 2010. She advised that the application required there to be a declaration of compliance against specified quality and safety regulations for each regulated activity at each location and that compliance had been assessed by having regard to the outcome detailed in CQC guidance. The Trust had declared non-compliance against one regulation but compliance was anticipated by the end of Q2 2010. The Chief Operating Officer / Chief Nurse and the Acting Medical Director were requested to liaise outside the meeting to determine how compliance with the CQC regulations could be built into existing operating procedures and the Director of Clinical Quality was requested to update the Governance and Risk Management Committee with progress as against **COO/CN /AMD** **DCQ**

the action plan in place to achieve compliance with this regulation and, to the meeting of the Governance and Risk Management Committee on 9 March and each subsequent meeting, to select a quality measurement and to provide a sample of the evidence supporting that quality measurement for the Committee to assess its sufficiency. The Chairman suggested that further of these regulations be considered at future meetings of the Governance and Risk Management Committee and that the CQC Quality and Risk Profile be used to prioritise the order in which evidence of the Trust's compliance with those regulations be reviewed. **DCQ**

<u>Resolved</u> – that (A) the Chief Operating Officer / Chief Nurse and Acting Medical Director be requested to liaise to determine how compliance with the CQC regulations can be built into existing operating procedures as standard, **COO/CN /AMD**

(B) the Director of Clinical Quality be requested to update the Governance and Risk Management Committee with progress as against the action plan in place to achieve compliance with this outstanding regulation (Regulation 23), and **DCQ/ TA**

(C) the Director of Clinical Quality be requested to select a quality measurement and to present to the Governance and Risk Management Committee on 9 March and each subsequent meeting, that quality measurement and to provide a sample of the evidence supporting that quality measurement for the Committee to assess sufficiency. **DCQ/ TA**

16/10/4 <u>Progress Report on Fractured Neck of Femur</u>

The Acting Medical Director outlined that he had requested the Director of Research and Development to work with the Clinical Director, Musculo-Skeletal Services and he confirmed that he would present a formal progress report on this item at the meeting of the Governance and Risk Management Committee on 9 March 2010. **AMD/ TA**

<u>Resolved</u> – that the Acting Medical Director be requested to present a formal progress report on this item at the meeting of the Governance and Risk Management Committee on 9 March 2010. **AMD**

17/10 SAFETY

17/10/1 <u>Presentation from Cancer Services and Haematology</u>

The Clinical Director, General Manager, Clinical Governance Lead and Head of Nursing / Cancer Centre Lead Nurse of Cancer Services and Haematology presented paper D which included information regarding the Directorate background, governance arrangements, improvements identified, reporting activity, inclusions on the risk register, nature and level of complaints and incidents in both Haematology and Oncology, the patient polling action plan, details of ongoing recurrent audits, infection control and a review of the performance scorecard showing 8 green and 4 amber ratings. Members noted particularly that the Directorate had been scrutinised externally and had achieved ISO 9001 and Jacie accreditations and had provided input into a haemophilia triennial audit, a review of haematology services and a peer review of cancer services across the Trust. 100% of complaints were processed within the statutory time limits, common themes had been identified and focus groups implemented to link themes to 'Caring at its Best' streams. This information was further supplemented by a report produced by the Director of Safety and Risk detailing exception information for the Directorate (entitled 'paper E').

In discussion on this item, members:

(i) queried what steps the Directorate took to ensure effective pain management and agreed that the Clinical Director of the Directorate be

requested to review Directorate inpatient polling results and to report to the May meeting of the Governance and Risk Management Committee on patient feedback relating to the effectiveness of the Directorate's pain management processes;

(ii) noted the difficulties in obtaining feedback on patient experiences and discussed how these could be best encouraged;

(iii) noted that the Directorate has been operating from a temporary aseptic suite, questioned whether this has posed a threat to the comfort of the centre. It was noted that the General Manager, Cancer Services and Haematology and the Chief Pharmacist were part of a steering group reviewing options but that the provision of a new suite had major cost ramifications;

(iv) made note of the number of complaints and incidents in Haematology and, from that, considered that pressure was being caused within Haematology between enthusiasm for new patients to be admitted as against the pressures on nurses assisting existing patients. It was agreed that more work was needed to assess patient demands and staffing needs;

(v) queried as to how the scorecard entry of 'amber' for mandatory training could be addressed and were advised that afternoon training sessions were taking place for consultant staff which were working well.

The Chairman complemented the Directorate on their obvious impressive teamwork, on the quality of their presentation and the supporting papers.

Resolved – that the contents of this presentation and associated documentation be received and noted.

17/10/2 Improving Safe Medication Practices across UHL

The Chief Pharmacist presented paper F, a report to explain the background to Electronic Prescribing and Medicines Administration (EPA), what an EPA solution will overcome, the benefits of an EPA solution and, in particular, highlighting improvements to patient safety, what EPA would look like, a project timeline, costings, likely efficiency savings and EPA Programme Board membership.

It was noted the EPA savings possible through strong clinical commitment in the embedding of an EPA solution and the adoption of new ways of working but the Members expressed some reservations as to the timescale proposed for implementation. It was noted that the delay in the approval of EPA was being caused by the pending completion of the integrated business plan and the prioritisation of capital projects but it was agreed that the Chief Pharmacist update the Governance and Risk Management Committee at its meeting on 11 May (3 months) whether and when the EPA project is to effected. **CP**

Resolved – that (A) the contents of this presentation and associated documentation be received and noted, and

(B) that the Chief Pharmacist be requested to update the Governance and Risk Management Committee at its meeting on 11 May (3 months) whether and when the EPA project is to effected. **CP**

17/10/3 Patient Safety Report

The Director of Safety and Risk presented the regular Patient Safety Report as paper G and highlighted:

- the procedures for dealing with Serious Untoward Incidents (SUIs);
- proposed changes to SUI reporting as required by the PCT;

- serious untoward incident theme actions;
- serious untoward incidents within UHL reported in January 2010.

In discussion following, the Director of Safety and Risk noted the need for the UHL Policy to reflect both the National Patient Safety Agency requirements and the PCT Policy. Members discussed several of the risk themes and actions and the Chair requested the Director of Safety and Risk to (i) update the Governance and Risk Management Committee on PCT changes to SUI policy, SUI theme actions and SUIs reported at its meeting on 11 May 2010 and (ii) to give consideration to the production of a best practice complaints template draft and to table this for consideration by the Governance and Risk Management Committee at its meeting on 13 April 2010. **DSR**

<u>Resolved</u> – that (A) the Director of Safety and Risk be requested to update the Governance and Risk Management Committee on PCT changes to SUI policy, SUI theme actions and SUIs reported at its meeting on 11 May 2010, and **DSR**

(B) to give consideration to the production of a best practice complaints template draft and to table this for consideration by the Governance and Risk Management Committee at its meeting on 13 April 2010. **DSR**

17/10/4 <u>Health and Safety Management Report</u>

The Senior Health and Safety Manager presented paper H being the Health and Safety Quarterly Report (third quarter 2009/10) to appraise the Governance and Risk Management Committee of progress towards Health and Safety management targets. The report provided information on the following:

- the number and type of serious accidents reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR);
- all health and safety training delivered by type and directorate;
- progress against the Annual Health and Safety Action Plan.

In discussion on this item, members:

i) noted that accidents reported under RIDDOR were the most serious accidents and necessitated a staff member being away from work for at least four days. In Q3, 14 incidents had been reported which was 3 lower than Q2 and continued a downward trend. Moving and handling and slips and trips remained the highest categories of RIDDORs which was typical across the NHS and in UK workplaces in general;

ii) were informed that UHL had set a target of reducing the total number of RIDDOR incidents by 10% as part of the Annual Health and Safety Business Plan but UHL had a projected reduction of 40% in 2009/10;

iii) were informed that 250 staff had attended Health and Safety training in Q3 2009/2010. After discussion, the Chief Executive queried whether the number of delegates attending Health and Safety training was proportionate to UHL's legal requirement to make health and safety training available to staff and requested the Acting Medical Director to review this position and to provide a verbal update at the Governance and Risk Management Committee meeting on 9 March 2010; **AMD/ TA**

iv) considered that significant progress had been made against 12 actions making up the Health and Safety Action Plan.

<u>Resolved</u> – that the report be received and noted.

17/10/5 <u>Review of the KPMG Review and Monitor Response to Mid-Staffordshire NHS Foundation Trust</u>

The Director of Clinical Quality advised verbally on the two reports (i) KPMG Learning and Implications from Mid Staffordshire NHS Foundation Trust (August 2009); and (ii) Management Response to the Internal Audit Report of Lessons Learnt from Mid Staffordshire NHS Foundation Trust (September 2009). She advised that UHL's internal baselining around the Health Care Commission review of Mid Staffordshire focussed on the recommendations primarily aimed at the clinical care pathway and monitoring by the Trust Board. The KPMG report focused around Monitor's role in authorising Trusts for Foundation Trust status and the focus on financial governance.

UHL had addressed some of the recommendations in the KPMG and Monitor Reports, for example, the undertaking of a risk assessment of Cost Improvement Programmes. The Director of Clinical Quality was requested to discuss both the KPMG Report and the Monitor publication consultation relating to an update to the Guide for Applicants – Quality Governance published on 5 February 2010 with the Director of Corporate and Legal Affairs and to update a future meeting of the Governance and Risk Management Committee with the conclusions reached. **DCQ/ DCLA/ TA**

<u>Resolved</u> – that (A) the verbal report was noted, and

(B) the Director of Clinical Quality be requested to discuss both the KPMG Report and the Monitor publication consultation relating to an update to the Guide for Applicants – Quality Governance published on 5 February 2010 with the Director of Corporate and Legal Affairs and to update a future meeting of the Governance and Risk Management Committee with the conclusions reached. DCQ/ DCLA/ TA

17/10/6 <u>Safeguarding Children and the Care Quality Commission Review</u>

The Chief Operating Officer/Chief Nurse presented paper I and advised that UHL had achieved 100% compliance against the target to ensure that all staff had undergone up to date safeguarding training appropriate to their roles and responsibilities by 31 December 2009. She reported that the revised adult safeguarding training strategy had been launched with targets monitored and to be reported and that a public declaration to confirm that UHL met the minimum requirements in Children's Safeguarding practice has been included on UHL's website following approval from local regulators. An outline was given as to the audit and inspection of safeguarding services, the Care Quality Commission requirements which made revisions to the core standards relating to Safeguarding practice and regarding the working group established to review the arrangements that UHL has in place to manage patients who may require restraining and to harmonise practice between the three hospital sites. Midwifery developments for Safeguarding and the existence and purpose of the Children and Adult Safeguarding Boards were detailed and the importance of Safeguarding Services was recognised as being of utmost importance to patient safety and therefore welcomed by UHL.

<u>Resolved</u> – that the report be received and noted.

18/10 RISK

18/10/1 <u>Risk Management Report</u>

The Director of Safety and Risk presented paper J which provided an update of UHL's key strategic risks and other risks scoring 15 or above and developments within the UHL risk management arena. The Committee was asked to note the contents of this report and to satisfy itself that the UHL key strategic risks and other risks scoring 15 or above continued to be identified, assessed and reviewed to ensure that risks were being actively managed to achieve a reduced target risk score

wherever possible.

In discussion which followed, it was enquired as to how the Governance and Risk Management Committee could add value. After recognising that strategic risk reporting had improved significantly in more recent times, it was agreed to feed any detailed comments on the papers presented today to the Director of Safety and Risk outside the meeting for her to consider.

Resolved – that the report be received and noted.

18/10/2 Chest Drains

The Director of Safety and Risk advised verbally and noted that the issue of compliance with the National Patient Safety Agency (NPSA) alert had been presented to the Trust Executive at its meeting on 27 January 2010 (Minute 164/09/2 refers) agreement had been reached with the Cardio-Respiratory Directorate to lead on the necessary actions to achieve compliance. The Director of Safety and Risk would be taking the Chest Drains Policy to the Policy and Guidelines Committee meeting on 22 February 2010. Following approval, this Policy would be disseminated throughout the Trust. The standardisation of chest drain equipment and other requirements of the NPSA alert were currently being undertaken by the Cardio- Respiratory Directorate under the leadership of Dr Catherine Free.

Resolved – that (A) the Director of Safety and Risk be requested to submit the Chest Drains Policy to the Policy and Guideline Committee meeting on 22 February 2010, and **DSR**

(B) following approval, the Director of Safety and Risk be requested to make arrangements for this Policy to be disseminated throughout the Trust. **DSR/ TA**

18/10/3 Flu Pandemic Update

The Chief Operating Officer / Chief Nurse advised verbally as to where the Trust was positioned in relation to the national bar set for staff vaccination and suggested that as the anticipated second wave of the pandemic had not happened, this had altered people's behaviour in relation to vaccination. Flu infections were down to normal winter levels and staff immunisation had been slightly below the average for the East Midlands.

It was agreed that this could be the last update on this issue unless management information indicates a noticeable increase in flu cases.

Resolved – that this verbal information be noted.

19/10 PATIENT EXPERIENCE

19/10/1 Patient Experience Group

The Director of Clinical Quality presented paper K which identified the priorities for the Patient Experience Group and provided an update on actions from the latest patient polling results, the Patient Experience Group Draft Work Programme and the plans for 'Story Telling' at the Trust Board. Each of the Clinical Directorates that had attended the Governance and Risk Management Committee had been asked to present their patient polling results so providing an opportunity to review Directorate performance alongside complaints and other quality indicators. Directorates' action plans for improving patient experience, once available, were to be reported back to the Trust Executive. The draft Work Programme was to be considered by the Patient Experience Group and performance indicators were to be agreed and added. She advised that a framework for

story telling to the Trust Board had been developed and was to be complimented by hard data in the quality and performance report, the intention being for the quarterly reports to focus on issues identified as requiring improvement in the areas of pain management, discharge, end of life care, patient information and communication.

The Chief Executive reported that UHL was still 'off the pace' in terms of progress made around the patient experience agenda and requested that the Director of Clinical Quality contact those Trusts perceived to be ahead on this agenda - suggesting Southampton and Sheffield – and to update her findings at the next meeting of the Governance and Risk Management Committee on 9 March 2010. **DCQ**

Resolved – that the Director of Clinical Quality be requested to contact those Trusts perceived to be ahead on the patient experiences agenda – Southampton and Sheffield suggested – and to update her findings at the Governance and Risk Management Committee meeting on 9 March 2010. **DCQ/ TA**

19/10/2 Quality and Performance Report – Month 9

The Chief Operating Officer/Chief Nurse presented paper L which provided a month 9 position statement against performance indicators encompassing quality, HR, finance, commissioning and operational targets.

Resolved – that the contents of this report be received and noted.

19/10/3 Equality Action Plan (including "Healthcare for all")

The Chief Operating Officer/Chief Nurse presented paper M which appraised members with an update on progress against the "Healthcare for all" strategy and equality priorities for 2010 and particularly provided information in respect of the following: background, monitoring, Pacesetters 'Make My Stay': Improving the experience of patients with a learning disability in acute care, project highlights, equality – policy development, strengthening leadership and governance, data collection and publication and ongoing engagement. She advised that UHL had done particularly well regarding learning disabilities and communication.

Resolved – that the contents of this report be received and noted.

20/10 QUALITY

20/10/1 Quality Accounts Update

The Director of Clinical Quality presented papers N – N2 which provided an update on the publication of quality accounts. Although the Department of Health had published the outcome of the earlier consultation on the format of quality accounts, the 'tool kit' was awaited. The outcome of the consultation was unsurprising in that the mandatory fields remained. The Quality Account Project Plan detailed the requirements for consultation / sign-off by OSC/LINKS and PCTs and the 30 day minimum requirement for this. The Director of Clinical Quality reported on a series of meetings / briefings she had attended with the Trust's membership and Patient Advisers and advised that she had met with the full time officer from JOSC to discuss Quality Accounts and would shortly be meeting with PCTs to discuss their expectations in terms of reporting. The Director of Clinical Quality was requested to present draft Quality Accounts for 2009/10 to the meeting of the Governance and Risk Management Committee on 13 April 2010. **DCQ/ TA**

Resolved – that the Director of Clinical Quality be requested to provide draft Quality Accounts to the meeting of the Governance and Risk Management Committee to be held on 13 April 2010. **DCQ**

UHL draft Quality Strategy

20/10/2

The requirement for the Director of Clinical Quality to provide a draft Quality Strategy to this meeting of the Governance and Risk Management Committee was deferred to the meeting of the Committee to be held on 9 March 2010. **DCQ/ TA**

Resolved – that the Director of Clinical Quality be requested to provide a draft Quality Strategy to the meeting of the Governance and Risk Management Committee to be held on 9 March 2010. **DCQ/ TA**

21/10 ITEMS FOR INFORMATION

21/10/1 Quarterly Data Quality and Clinical Coding Performance Report

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

21/10/2 Finance and Performance Committee Minutes

The Minutes of the Finance and Performance Committee meeting on 25 January 2010 would be submitted to the Governance and Risk Management Committee at the meeting to be held on 9 March 2010.

Resolved – that the position be noted.

22/10 ANY OTHER BUSINESS

There were no items of Any Other Business.

23/10 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 Trust Board at its meeting on 4 March 2010:

- **Cancer Services and Haematology Presentation and papers D and E;**
- **Improving Safe Medication Practices across UHL presentation and paper F.**

24/10 DATE OF NEXT MEETING

Resolved – that the next meeting of the Governance and Risk Management Committee be held on Tuesday 9 March 2010 from 8.00am in Conference Rooms 1A and 1B, Gwendolen House, Leicester General Hospital. **ALL**

The meeting closed at 10.55 am.

Adrian Whalley
Temporary Trust Administrator