NHS Resolution

Board meeting minutes (Part 1)

12 July 2017
09:00 – 13:00
Blue Room 1, First Floor, 151 Buckingham Palace Road, London

Present	
Ian Dilks	Chair
Andrew Hauser	Non-Executive Director
Keith Edmonds	Non-Executive Director
Mike Pinkerton	Non-Executive Director
Helen Vernon	Chief Executive
Vicky Voller	Director of NCAS
Denise Chaffer	Director of Safety & Learning
Joanne Evans	Director of Finance & Corporate Planning
John Mead	Technical Claims Director (Associate Board Member)
In attendance	
Alan Hunter	Director of Claims
Ian Adams	Director of Membership & Stakeholder Engagement
Cheryl Lynch	Representative of DH Sponsor Team
Tinku Mitra	Head of Governance
Julia Wellard	Executive Assistant (Minutes)
Apologies	
Mike Durkin	Associate Non-Executive Board Member

1 Administrative matters

1.1 Chair's opening remarks and apologies

The Chair opened the meeting by welcoming everybody and noted that apologies had been received from Mike Durkin.

1.2 Declaration of conflicts of interest of members

There were no conflicts of interest to note.

1.3 Minutes of Board Meeting held on 17th May 2017

Subject to minor amendments, the minutes of the Board meeting held on 17th May 2017 were APPROVED and a copy signed by the Chair.

1.4 Review of actions from Board meetings

The actions from the last Board meeting were noted and the closed actions removed.

The following actions were rolled forward:
Finance performance – a report to be submitted on the review of the Purchase Ordering process for the second half of the calendar year – will be brought to the November meeting.
Mediation Service – Director of Claims to prepare a paper on the key benefits and issues from the mediation service to the September Board.

The following actions were closed:
Board governance – the Head of Governance has checked and all reports which are required to be seen by the Board have been reported over the last year.
Early Warning Systems cross function triggers – this is being discussed at the informal Board meeting following the main Board meeting.

2 Operational items

2.1 Chief Executive's Report

Legal panel tender
The legal panel tender process has now completed and the three legal panels were appointed on 26th May for a period of four years with 10 firms (26 offices) appointed to Lot 1 (clinical negligence), 5 firms (14 offices) to Lot 2 (non-clinical) and 12 firms to Lot 3 (regulatory health and disciplinary law). There is good geographical coverage across all lots and a number of value adds were put into the tender to assist in supporting delivery of the strategy. The panel have already supported a number of learning events and a panel conference took place on 28th June which discussed the strategy, business plan, performance measures and priorities for the new panels as well as a number of current activities such as mediation and the early notification of incidences of brain injury at birth. The Director of Claims and his team are working on the distribution of panel firms to trusts.

Personal injury discount rate
We submitted our response to the MoJ personal injury discount rate consultation and are waiting to hear the outcome. The impact of the change is being monitored closely.

Insurance consultancy
The tender for insurance consultancy to advise on CNST pricing has now concluded and has been awarded to Marsh Risk Consultancy to provide expert advice on the options to build a forward view into CNST pricing. The contract is for a duration of 6 weeks which commences on 12th July with an expected report to the Board in September on progress. The Chief Executive, Director of Finance and Head of Business Development are meeting with Marsh on 13th July. The aim is that Marsh will review what has already been done to avoid duplication and undertake research on how maternity risk is priced elsewhere i.e. internationally.

Each Baby Counts
The Chair, Chief Executive, Director of Safety and Learning and Team Leader for the Early Notification Scheme attended the Royal College of Obstetricians and

Gynaecologists (RCOG) Each Baby Counts Clinical Engagement Forum on 21st June which focussed on key clinical actions needed to improve the quality of care and prevent future cases. Three quarters of the cases reviewed identified that there may have been a different outcome had the care been different. We continue to work closely with the RCOG and the Director of Safety and Learning is on the Each Baby Counts advisory Board.

MPS Report
A report has been published by the MPS on 'The Rising Cost of Clinical Negligence, Who Pays the Price' which references NHSR financial data and provides an analysis of international experience and solutions to the rising costs. We have issued a statement in support of the publication in particular the proposal to research why claims are brought.

The Board noted the Chief Executive's Report.

2.2 Performance review

The performance review detailing financial performance and key performance indicators for the period under review was presented.

The Board noted the performance report for the Finance, Claims, NCAS, Safety and Learning and FHSAU functions.

3 Management proposals requiring Board input or approval

3.1 *FHSAU Extension of Panel Member Appointments – Chairs*
The Board were asked for approval to reappoint five panel member Chairs for a further two years to 31st July 2019. All five Chairs have successfully completed appraisals. This is the final extension of appointments for the current Chairs and a further round of recruitment of Chairs will be taken forward towards the end of 2018 which will be staggered going forward to ensure a refreshing of experience and assist planning.

The Board approved all five Chairs are extended for a further two years.

4 Liaison with Key Stakeholders

4.1 An update on recent communications and stakeholder engagement was presented detailing key activity relating to proactive/reactive media management, issues management, digital communications, stakeholder engagement and events across NHSR. Going forward, monthly reports will be submitted to Board (in between meetings) to give Board members a real time snapshot of NHSR activities.

It was noted that there had been no press statements in the pre-election period.

The summer panel conference took place in London on the 28th June and the Director of Membership and Stakeholder Engagement thanked those who attended and took part and helped with the delivery of the event which proved very successful. There will be three panel conferences throughout the year with a further conference

planned for the autumn on 8th and 9th November in London and a winter conference in January/February.

This year we took a more proactive approach to our attendance at the NHS Confederation Conference by organising a series of one to one meetings with members and stakeholders at the conference which proved to be a much better use of the senior management team's time.

The new web holding page for NHSR is now up and running which features the Strategy and the 2017/18 Business Plan demonstrating that the content is of interest as session time is showing up to three minutes which is an improvement on prior periods.

The new corporate newsletter 'Resolution Matters' was recently launched which will be a quarterly publication. The next version will be aligned with the launch of the Annual Report and Accounts. There is currently 25% of recipients opening the newsletter but this is expected to increase as it is embedded.

It was noted that attendees at a recent strategic clinical network meeting in June were not aware their trust had a scorecard. There are some organisations who are sharing it with others but it is not being circulated as widely in trusts as it should be. Attendees at the meeting were advised to contact their claims and legal department for access to their individual scorecards. There is a possibility that this could be adapted for the website to catch attention. The Getting it Right First Time (GIRFT) initiative has also had an involvement in raising awareness of scorecards and we are also working with NHS England and NHS Improvement around increasing the awareness.

Question was raised whether the 'Did you know' leaflets was demonstrating a reduction in incidents and it was suggested that we should take a snapshot of the database at the time leaflets are launched and then a snapshot a year down the line to see if there has been any improvement. For shorter tail claims this may be a feasible approach to measurement.

Action: DoS&L

The Board noted the Stakeholder Engagement Report.

5 Key Developments

5.1 *ABC v St George's Healthcare NHS Trust and Others*

This case relates to the claimant's father who was convicted of manslaughter on the grounds of diminished responsibility for shooting and killing the claimant's mother and sentenced to a hospital order under the Mental Health Act. The father, whilst in detention, was diagnosed with Huntington's Disease which is incurable and fatal and there is a 50% chance of the disease passing down the blood line. The father refused permission for his daughter to be made aware of his diagnosis as she was pregnant. Subsequently a clinician accidentally informed the claimant of the diagnosis and several years later was herself diagnosed with the disease. The claimant brought a claim against various trusts involved in her father's care on the basis that had she known about her father's condition she would have sought a diagnosis herself earlier and, if confirmed, terminated her pregnancy.

The Court of Appeal decided that it was arguable that it was fair, just and reasonable to impose on the defendants a duty of care towards the claimant despite clinical confidentiality. The case has, therefore, been reinstated and remitted to the High Court for trial to on the facts. This claim, if successful, would have implications for change in clinical practice.

The Board noted the position.

6 Oversight of Key Projects

6.1 *Local Incident Reporting Provider (LIRP) Pilot Project*

The Local Incident Reporting Provider Pilot ran between December 2016 and May 2017 with four member Trusts. The aim of the pilot was to explore common contributory factors identified in orthopaedic and obstetric claims which could be identified earlier and reduce harm. The pilot proved to be a success with all member trusts benefitting from the shared learning within their organisations and identified improved approaches to organisations working together locally in terms of how their data correlates across incidents and complaints. The main findings from the report were that there is a need for specialist investigatory health training that will inform and advise improvement to complaints handling, candour, serious incident reporting, complex investigations across internal directorates and external health agencies, and consideration of development and hosting of an external expert bank of clinicians that would support trusts with an independent view on investigations. The pilot did pose some difficulties in terms of effective communication between internal teams and across NHS/Social networks which will need to be considered for wider rollout.

The key recommendations from the pilot are:

- Share findings across NHS Resolution (e.g. Learning Faculty and Extranet Working groups, business development and Membership Staff Engagement) as well as National safety improvement projects and relevant Arm's Length Bodies e.g. Getting it Right First Time (GIRFT), Developing a Patient Safety Incident Management System (DPSIMS), NHSI and NHSE safety teams for the purpose of sharing the learning and stimulating future innovations in data analytics.
- Safety and Learning team use findings of this pilot to support requests from individual members.
- Further consideration is given on whether to roll-out the pilot further, subject to agreed support from incident reporting providers.

Next steps are to:

- Share findings and observations more widely across NHS Resolution as well as its members through the corporate newsletter for the purpose of endorsement or elimination of the recommendations.
- Use findings of the pilot to support future requests from individual members that wish to improve patient safety and learning.
- Give further consideration on whether to roll-out the pilot further, subject to agreed support from incident reporting providers.
- Share findings with National safety improvement projects and relevant Arm's Length Bodies for the purpose of sharing the learning and stimulating future innovations in data analytics.

The Safety and Learning team will be discussing taking the project forward with the panel at the next collaborative meeting. The team also have meetings arranged with Datix and Ulysses to agree expectations, validity and timeframe for taking forward the recommendations.

Question was raised on the aim of the pilot "to explore common contributory factors identified in orthopaedic and obstetric claims which could be identified earlier and reduce harm" and how this can be measured or how we can demonstrate that harm has been reduced. We are aware that trusts have produced reports from the pilot which have been presented to their Boards and outputs from the pilot have identified that complaints could have been avoided if they had been handled in a different way. The Safety and Learning team are working closely with members to get a better consistent collection of data in order to measure this going forward.

It was suggested that when we propose new projects that they should be mapped with the strategy on how improvements have been demonstrated so when reporting to the Board this could clearly be identified in the coversheet.

Another question was raised on whether there was another route where we could influence the findings in trusts and it was suggested that we could liaise with NHS Improvement to include it in their good practice for Boards.

The Board noted the position and agreed to support next steps.

6.2 *Feedback on Mindful of the Gap Bristol sharing and learning event – 21.4.17*

A report on the evaluation of the Mindful of the Gap event was presented. The purpose of the event was to discuss the challenges and sharing solutions when a patient journey involves acute, community and other settings, consider the use of human factors' awareness to keep patients, staff and the public safe when caring for mental health patients across all settings, explore the issues of leadership to enable true candour in a just culture across all health settings, and facilitate networking and sharing of models and best practice. The day was interactive with breakout workshops and a video from the day was produced for attendees joining future events. The format of the events where we provide a platform for members to come together is working well which we will be continuing for all future events.

The intended outcomes of the event were as follows:

- To bring together a number of members, public sector bodies, agencies with families and patients with a shared interest in the issues, bearing in mind joint arrangements with other partners for mental health care e.g. with the police.
- The event would facilitate networking between peers, the sharing of successful models of practice.
- Learning in breakout sessions from experts in specific areas of learning from incidents.
- Learning from case stories, patient and family involvement and experience to ensure their voice is heard in parallel to those of healthcare professionals.
- Through the process of exchange, interventions that may be useful for dissemination to the wider NHS will be identified.
- Knowledge and experience will be shared and networks created to support

organisations/individuals in sustaining their improvement effort.

There were three powerful presentations as part of the "Voices" section of the agenda:

- A successful model of family liaison support ensuring patients and families are supported through day one of an incident to conclusion.
- A patient and a father who gave the perspective of two different NHS experiences both for his own condition and the contrasting tragic outcome for his son where he and other families were not listened to.
- A case story "Charlie's story – learning from tragedy" delivered by South West Ambulance Service on "Ensuring consistent emergency response to convulsions in children".

The event was attended by member trusts, Arm's Length Bodies, collaborating partners, panel firms and NHSR staff.

Two further events are planned on "Inquests: what lies beneath" and mental health.

The Board noted the evaluation from the event.

6.3 *Summary report on Bid Incentivisation Scheme projects*

Following the formal UCL evaluation of the bids relating to maternity and A&E which was presented to the Board in March, a summary of the other areas of improvement was presented including falls, safety culture, sepsis, surgical, deterioration, human factors, test results, cardiac arrest, handover and pressure ulcers of which there were 31 bids.

The summary identifies the area of improvement, how the funding was implemented, the difference the funding has made and the outcomes.

In terms of next steps, the Safety and Learning team will include a review of aspects of reported measures/interventions from the bid scheme which will consider:

- Potential for buddying matches and sharing of best practice, innovative ideas
- Further progress on some strands of interventions
- Case story work that could be developed as a result of the implementation
- Reviewing with trusts resources amenable to publishing by NHSR to share across the NHS with a focus on the ask and offer concept.

It was noted that some outcomes were very impressive and we should establish whether there was any possibility of publishing them, for example in our newsletter, as well as asking members to present at conferences on what has and has not gone well and present them as examples of good practice.

Question was raised on what will happen to staff in trusts who were employed as part of the funding they were given, in particular whether the work they have done will continue. It was suggested that we could undertake a further review in a year's time to see how the work has continued.

There have been lessons learned from undertaking the incentivisation scheme and if

we were asked to do it again changes would be made to ensure there was regular reporting of how the funding has been spent.

The Board noted the summary report.

7 Board Committee Reports and Minutes

7.1 *Minutes of the Audit and Risk Committee – 10th May 2017*
The minutes of the Audit and Risk Committee meeting held on 10th May were noted by the Board.

7.2 *2016/17 Annual Report of ARC to the Board*
The Annual Report for the Audit and Risk Committee for 2016/17 was presented. The report details the role of the Committee and the number of meetings attended by each member as well as reflecting on the work of the Committee for the year which included:

- Annual Report and Accounts for 2016/17
- External Audit – updates from NAO on their work on progress against the audit plan
- Internal Audit – updates on progress against the plan of work and recommendations from internal audit.
- Procurement of internal audit services
- Assurance from other committees
- Risk and Assurance which included an upgrade and professionalising NHSR's risk framework.
- Review of the ARC terms of reference.

The Board noted the 2016/17 ARC Annual Report.

8 Other matters requiring Board attention

8.1 *Hospitality and Gifts Register*
The Hospitality and Gifts Register was presented showing all offers of hospitality which staff have attended as well as gifts received.

It was noted that there were no offers of hospitality by the panel during the panel tender and panel firms have been reminded about the rules concerning hospitality.

There are events which are considered appropriate for members of staff to attend as they are important networking and discussion events or educational events which are organised over lunch or dinner. It was suggested that these events are explained more fully on the register.

The Director of Claims will write to the panel to say that the Board reviewed the hospitality register and to remind panel of the applicable rules.

Action: DoC

The Board noted the Hospitality and Gifts Register.

9 Any Other Business

There was no other business to note.

10 Date and Venue for next meeting

10.1 The next Board meeting is scheduled for Wednesday 6th September 2017 at 9.00am and will be held in BR1, First Floor, 151 Buckingham Palace Road, London.

Signed ……………………………………………………….………

Date ……………………………………………………………….…