The Royal Wolverhampton Hospitals NHS Trust

Minutes of the Board Assurance Committee held on the:

Date	**28 June 2012**
Venue	**Board Room, Corporate Services Centre**
Time	**12:30-14:30**

Present:	**Name**	**Role**
	B Jaspal Mander (BJM)	Non Executive Director - CHAIR
	J Vanes (JV)	Non Executive Director
	D Loughton (DL)	Chief Executive
	M Ogden Meade (M OM)	Chief Operating Officer
	C Etches (CE)	Chief Nursing Officer
	M Arthur (MA)	Head of Governance & Legal Services
In Attendance:	**Name**	**Role**
	S Khunkhuna (SK)	Governance IM&T Lead
	J Phazey (JP) / G Wilde (GW)	Healthcare Governance Managers Div 1 / Div 2
	S Reilly (SR)	Patient Experience Lead
	Y Hague (YH)	R&D Directorate Manager
	Dr M Cooper (MC)	Consultant Microbiology
	L Nickell (LN)	Head of Education & Training
	Mr K Stringer (KS) / **L Myatt (LM)**	Finance Director / Patient Access Manager
	T Morris (TM)	*Attending to take the minutes*
Apologies:	**Name**	**Role**
	Dr J Odum (JO)	Medical Director

Item No		**Action**

1	**Apologies for absence –** were noted.	
2	**Declarations of Interest –** There were no declarations of interest to note.	
3	**Minutes of Previous Meeting dated 26 April 2012** **RESOLVED: Agreed as an accurate record.**	
4	**Matters Arising & Action Summary Report** 4. Action regarding FOI process was closed. 4.1 MA advised that a section has been included in the dashboard regarding FOI breaches and community data had been circulated following the last meeting. 4.2 BJM advised she had picked up the action regarding risk 2448 Mental Capacity Act with the Chief Nurse and Deputy Chief Nurse for Transformation & Workforce and this is being pursued. There was no major issue and all measures put in place are having an impact. Training needs to be maintained.	
5	**Board Assurance Dashboard** MA reported that key areas have been through the various committees for monitoring. She highlighted the following: Patient falls continue to increase. 366 have resulted in no injury. Of 91 reported injury or ill health; none were STEIS reportable. Work regarding care bundles continues. The committee discussed that where nurses are situated in bays, there is a reduction in patient falls however there is resource cost attached to this. Currently we report all falls. CE agreed to pick up comparison of how we report true falls against minor falls with the Falls Committee as an action for them to do. The committee also discussed mattresses. It was advised that we have plenty of mattresses but they are sometimes in the wrong place. It was noted that the tracking system only went live this week and would be monitored. From July, the PCT will no longer send out pressure relieving mattresses and we will start to see our stock replenished. It was highlighted that there may be an issue with residential homes transferring patients to nursing homes as they do not have the funding which could have an impact on the Trust operationally. MA highlighted complaints; The Gynae Never Event action is closed. The Urology incident had been downgraded to yellow. The directorate have taken on board comments and this complaint will be closed off.	**CE**

	Indicators are red if there are any Riddor incidents. However it was explained that documentation was not available at the time for this particular RIDDOR but that it WAS reported to the HSE on time. MA advised that work continues with directors regarding KPI's; NHSLA work etc. As of the end of March; all safety alerts have been closed off going back to 2009. There are still no overdue alerts. Nine are open; 18 closed off. CE stated that regarding ambers alerts; we need to ensure they do not tip into the red. It was explained that there is a three month period for Alert Leads to undertake a gap analysis / feedback and also for any concerns on alerts that might run over to be notified to Governance. The Annual Audit is now more in-depth. Boxes highlighted in black signify audits that are scheduled to take place. MA agreed to check what is included in Industrial i.e. whether this is part of Estates and The Chestnuts / IP / Ward Projects. MA stated that action plans are followed up by H&S leads. The committee noted that a lot of work is required prior to November and resource challenges regarding TCS. Some areas have been rescheduled in order to ensure West Park / Acute work is completed. **RESOLVED: The committee noted the report.**	**MA**
6	**Board Assurance Framework** SK advised there were 9 risks contained with the framework and significant changes had been discussed at Trust Board. He stated that there are two new red risks; 2962 Health Visiting Services and 2965 Failure to reduce Never Events: The committee discussed risk 2962. There has been progress against this risk and action plans will be followed up. There had been a leadership change of the Chief Operating Officer and a Service Improvement Group which has been set up will meet every two weeks to oversee planned changes. Recommendations will be picked up and it was advised that this is multi-agency. CE stated that an individual external agency will be managing the O.D. Agenda. Discussion was also held that compared to the Black County Cluster, we are not that different, however there has been a delay with progress in Wolverhampton. The SHA have set up a review for September for each Health Visiting Service but there were no concerns with the service itself. DL added that this is a recurring theme; known issues by the PCT when managing some of the services were not addressed and work continues around this. Change of leadership has had an impact.	

	The committee discussed risk 2965 regarding process of acknowledgment and ownership. A series of events have been held and lessons shared regarding Never Events; and attitudes have started to change since January. DL added that he had attended a senior staff meeting and it is understood by Consultants that their professional registration is on the line. CE explained that there is a high level of confidence regarding which medical charts are used and it was in the plan to align these charts. Issues such as organisational lessons, systems and processes, team / individual contributions and communications have been looked at and a Never Event is not usually just purely down to an individual, team or process. There are normally a number of factors. Clinicians are reminded to write in patient notes across the board; not just for surgery. The Association for Peri-Operative Practitioners were invited to review Never Events and training is being considered which JA (NED) will be involved in work regarding this. BJM pointed out that following consultant interviews; knowledge of Never Events was not good and consistency is required. MA added that communication needs to be through the professional route to i.e. consultants not just via risk management governance and needs communicating down too. **RESOLVED: BJM stated that the Board Assurance Framework had been discussed at Trust Board regarding detail and processes and she would pick up any further questions outside of the meeting with the relevant Executives.**	
7	**NPSA / NRLS** SK presented the feedback report. He highlighted page 2 and stated that we are a healthy reporter of incidents however 1.2% of incidents reported do include some form of personal identification data. SK advised that this equates to a small number and has decreased further to 0.4%. Incidents are screened monthly. Table 2 provides detail of harm. We report lots of near misses but no harm incidents have been reported. CE pointed out that this is important information for Non Executive Directors to be aware of which shows good healthy reporting regarding near misses. Table 3 provides detail of types of incidents. It was highlighted that pressure ulcers fall under the category of 'Treatment Procedure' and mattresses would fall under 'Medical device / equipment'. SK informed the committee that synergy incidents contribute to this category but non conformities are being looked at and this will not be included in future reports. The committee held a discussion and it was agreed that an audit trail is required and that data should not be excluded for Synergy. 'Patient accident' percentage at 22% for the organisation was a positive figure compared with incidents across the cluster. It was agreed that the report be forwarded to JA and the Chairman which could be used for Monitor evidence. SK pointed out that for Table 3: Omitted medicine / ingredient; included old data regarding allergy boxes. Figures have since improved.	**CE**

	RESOLVED: The committee noted the report for assurance.	
8	**SUI Action Tracking Report** JP stated that this was an exception report and some actions are either passed their deadline or are partially complete. The report is split between Division 1 and 2: Division 1 continues to progress well. Some actions are overdue / partially complete due to staff not available regarding training. Incident 84299 (Never Event / retained wet pack) continues to be monitored. It has been acknowledged at divisional level that it is difficult to track actions routinely. Incidents are tracked via divisional governance scrutiny and by performance reviews. GW agreed that for Division 2 it is also difficult to track actions due to the complexity and nature of incidents but that assurances continue to be gained. Process is changing further to commencement of new working arrangements and team relations are being strengthened. Processes continue to be streamlined. BJM requested that gaps regarding dates and assurances and / or issues where leads cannot meet targets be fed back to her. The committee went on to hold a discussion regarding ownership by divisions of outstanding actions. CE stated that it is intended that divisional teams will be requested to present the SUI reports in the future at QSC. It was agreed that JP/GW work with the Chief Operating Officer regarding gaps and where straight forward, these be actioned. Where there is on-going issues; leads to be requested to attend the next BAC meeting. **RESOLVED: JP/GW to work with the Chief Operating Officer regarding gaps contained within the report and leads to be invited to attend the next BAC where necessary.**	**JP/GW**
9	**Patient Experience Survey / PET Results** SR presented the report and advised that since March questions have been re-reviewed and consulted with Matrons regarding complaint and PALS themes. She highlighted the six categories on page 2 of the report. SR explained there had been an I.T. issue with the new survey and in April there had not been many volunteers available. Breakdown is provided by quarter and a red / amber green status has been introduced. She highlighted the diagrams on page five. Four wards have been added to the survey (incl. West Park). Volunteers are also needed here and it is intended to ask student nurses. Discussions will be held with Practice Placement Managers and Matrons.	

	The committee discussed the report regarding data being more reliable for the Trust as opposed to wards. It was agreed that explanation be included in future reports in order to understand what the bar is set at. SR advised that the percentage of patients surveyed respond positively. As there are limitations to collection of data, data needs to be triangulated and comparison provided for wards as well as the Trust. Awareness is being raised with matrons. The committee also discussed complaints (red 58%) and whilst a lot of work has been undertaken; response letters still contain minor errors. A new Complaint Manager has been in post for three weeks and has highlighted that targets are unrealistic. Due to his experience within another trust; there will be as element of benchmarking. The Deputy Chief Nurse meets with him on a regular basis. SR added that there were an increased number of complaints received February – April; however a lot were completed in 26-27 working days. The Complaints Manager will look at how we undertake surveys and the type of responses that are being received. It was agreed that a report should come back in October 2012. JV enquired about 'Way Finding'. DL stated that this will not go live if it is not ensured 100% that the system will work. Concerns are regarding administration, not signage. CE added that volunteers will be placed in strategic positions when the system goes live. **RESOLVED: Next report agreed for October 2012 (including complaints).**	
1.0	**<u>Committee Quarterly / 6 monthly Reports</u>**	
10.1	**Compliance Committee** **RESOLVED: The report and minutes were noted.**	
10.2	**Quality & Safety Committee** It was advised that the Pressure Ulcer Report had been presented and two year updates will be provided to Trust Board. **RESOLVED: The report and minutes were noted.**	

10.3	**Research & Development** YH presented the report and advised of an un-triggered MHRA audit. There were only two minor issues picked up and these related directly to Novartis and had no impact on the Trust. The audit had gone well. YH stated that the department has experienced an increase in MHRA Inspections but trust systems and processes are not affected unless specifically involved by department i.e. Pharmacy had performed well. YH highlighted the incident reported as a serious breach where the patient did not have chest x-rays reported. An RCA has been completed by the Medical Physician and submitted to the Governance Team. The action plan was included as appendix 1. YH added that there are no major incidents contained within the R&D risk register. YH went on to state that R&D is fairly new to NHSLA; however compliance is on track for completion of evidence by the end of July. MA pointed out that samples regarding NHSLA standards for level 2 was not always required from R&D previously. R&D are working with the Governance Officer Lead and YH stated they aim to be 100% compliant as a whole. Local data collection has been set up for Research Governance and archiving of trial data and a register will be implemented due to outside targets as well as key Performance Indicators. Work continues with Division 1 and 2; rather than working in isolation. It was advised that the MHRA registry has been recorded and the Governance Team regularly monitor and check quality of data. **RESOLVED: The committee noted the report for assurance.**	
10.4	**Infection, Prevention & Control** Dr MC presented the report which had also been presented to Trust Board. The Code of Practice is fully implemented and monitored within RWHT. Trust Board members are happy with processes which are considered safe and the only issue is whether we are ticking all boxes regarding audit evidence. Dr MC highlighted criterion 1; work is on-going and to build up areas / restructure teams. BJM requested dates / end dates against actions for future reports. It was stated that the full report is updated and contained on Performance Accelerator. The committee also discussed IV lines. The IV Team can monitor lines in hospital and train staff. DR MC stated that regarding ambers; continual checks take place. Criterion 10 is around safe sharps. An EU Mandate for March 2013 is in place and we have to get this right. Robust plans are in place.	**MC**

	CE enquired about the C.Diff target for 2011-12 (target of 57). West Park had been excluded from the DOH target who do not accept West Park as part of RWHT. If these cases were added in, the figure would be 69. Monitor is happy for both to be included as one. Year to date performance as of 27 June for Q1 is 10 for New Cross and 1 for West Park. Dr MC stated we are within target. **RESOLVED: The committee noted the report for assurance.**	
10.5	**Education & Training** LN presented the report and stated assurances which are linked such as NHSLA standards 3 & 5 and CQC. She highlighted the exceptions and risk table and stated that leads produce an action plan which is monitored at the Induction & Mandatory Training Group. Compliance will be 95% by the time the NHSLA inspection is due. She went on to update on the following: Board member training is on-going. Publicity initiatives are being carried out to raise awareness e.g. hand hygiene. Hand washing is an important target however as this is included in Hand Hygiene Training, the assessor advised she would accept this when she visited during the pre-assessment. Compliance reports are now being produced monthly to include minimum data set and itemised topics. A data dump is being completed daily onto the training database and work continues with I.T. LN highlighted provision of education funding and advised that there will be a tariff system with funding to follow the student. There will be a tally and there should be a benefit as more income will be provided. Monitoring of LETB and LETC will continue. Failure of Level 3 for standard 3; standard 4 and 5 - Supervision of medical staff in training was previously only level 1 but is now level 2 following appeal. Data had been drawn from the GMC. Last year's survey showed 11 green outliers and 4 red which have been addressed. The committee discussed whether risk ratings are achievable. It was advised that they were and if we have good compliance with good action plans in place we should achieve our target. Any concerns are in hand. Training is being increased. MA added that work is on-going with investigations, complaints and claims. Band 6 training sessions are being held and also ad hoc training for staff who are not nurses with provision of E-Learning packages. Senior Management Training is now an NHSLA requirement and sessions have been held this year. It was advised that regular meetings are being held with subject leads and issues are being escalated to the Chairs of various committees e.g. HRC. **RESOLVED: The committee noted the report for assurance.**	

10.6	**Integrated Health Records Committee** KS and LM attended the meeting to present the report and advised that Dr M Cusack had stepped down as Chair and was replaced by Dr B Singh for the combined committee. He stated that there are challenges with not using paper and just electronic records. LM provided an update on the following: The harmonised Health Records Policy (OP07) now incorporates community and standards regarding electronic records. The policy is in draft and has been given a one year review date. Mandatory training (implementation of Generic Standards developed by the Royal College of Physicians) compliance is not high however plans are in place to address this. There is a package on the KITE site and work is on-going to raise awareness and with Junior Doctors. Currently we are 17% compliant and there will be a lot of resource required to achieve this. The target group has been reduced however this includes administration staff too. Community records integration links into the work of the policy. Historic storage and archiving will be a big piece of work to address. Work is on-going to develop electronic records including the Web Portal and I.T. are working closely with departments regarding paper no longer to be filed in the records e.g. review results. Pilots are being carried out and two specialties are fully note-less so far. The first two inpatient areas are being considered for trial. The committee discussed capacity of the Server Farm and concerns regarding increased usage. It was advised that we are on track and benefits will probably not be seen until mid-July; however tight control is being maintained. The committee noted it was good to see how much work is on-going. **RESOLVED: The committee noted the report for assurance.**	
11	**<u>Issues of significance arising for Audit committee</u>** JV formally closed off the action regarding 'a change of approach on information looked at' requested by Mr Sutton who has now left the organisation. This related to the CQC Compliance Report. Where there are issues with reports; these are looked into. It was advised that the Francis Report is due to be presented to the July QSC meeting. Mental Health regulated activity has been taken up by separate action plans and it had been agreed that this would not come to BAC as a bespoke report.	

12	**Issues of Significance for Trust Board** **RESOLVED: BJM to provide a report to the July Trust Board.**	
13	**Any Other Business** • **Terms of Reference –** MA advised that this was an update regarding approval in April and also a section included; 6.4 to provide Board Assurance Committee minutes to Trust Board. Audit trail also required for NHSLA. • **RESOLVED: Approved by members of the Committee.**	
10.0	**Date and time of next meeting:** **30 August 2012 @ 12:30 – 14:30** **Conference Room, Hollybush House**	

COMMITTEES OPEN / CLOSED ACTION SUMMARY REPORT – 28 June 2012

ITEM	Action to be taken raised from the meeting	Lead	Carried forward from	Committee Review date	Status
5	BA Dashboard: CE to pick up comparison of how we report true falls with minor falls with the Falls Committee for their action. MA to check the Audit Plan – sections re Industrial and The Chestnuts / IP / Ward Project for clarification.	CE MA	June 2012	August 2012	**Agenda Item Open** **Open**
6	BA Framework: Further questions to be picked up outside of the meeting with Executives where necessary.	BJM	June 2012	August 2012	
7	NPSA/NRLS Report: CE to forward report to JA and the Chairman regarding Monitor evidence.	CE	June 2012	**December 2012**	**Open**
8	SUI Action Tracking Report: JP/GW to work with C.O.O re gaps and leads to be invited to attend the next meeting where there are issues.	JP/GW M OM	June 2012	August 2012	**Agenda Item**
9	Patient Experience Survey / PET results: Report agreed for October (including Complaints)	SR	June 2012	**October 2012**	
10.4	Infection, Prevention & Control: End dates to be included in the next report.	MC	June 2012	**December 2012**	
12	Issues of Significance for Trust Board: BJM to provide a summary report to Trust Board – July 2012	BJM	June 2012	**July 2012 Trust Board**	**Closed**