The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	20 May 2013
Title:	Board Assurance Committee Annual Report
Executive Summary:	This is the annual report of the Board Assurance Committee, which has already been presented to and discussed by the Joint meeting of the Audit Committee and Board Assurance Committee on 25 April 2013.
Action Requested:	To note the report.
Report of:	Balsinder Jaspal Mander – Non Executive Director
Author: **Contact Details:**	Tel: 01902 695114
Resource Implications:	Nil
Public or Private: **(with reasons if private)**	Public Session
References: **(e.g. from/to other committees)**	Joint Audit Committee & Board Assurance Committee – 25 April 2013
Appendices/ References/ Background Reading	Appendix 1 – Board Assurance Committee Attendance 2012/2013
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

THE ROYAL WOLVERHAMPTON HOSPITALS NHS

BOARD ASSURANCE COMMITTEE
ANNUAL REPORT
2012/2013

Balsinder Jaspal Mander
Non-Executive Director
Chair of Board Assurance Committee
April 2013

1.0 Executive Summary

The BAC has monitored all the essential standards of quality and safety throughout the last year to ensure that there is not only compliance but that the Trust strives towards providing excellent patient care.

The previous year saw a review of the committee structures in the Trust, this year has enabled the committees to be embedded into the governance structure. Changes were also made to monitoring of risks by the introduction of the Trust risk register with a detailed tracking system. There was also a mapping of risks on the BAF (Board Assurance Framework) and the Trust risk register against the strategic objectives.

This year through the BAC and the supporting sub committees, the organisation has reviewed in detail its compliance and risk status in regard to the following key areas:

- Maintenance of an accurate Board Assurance Framework
- Review of Divisional Risk Registers
- Hospital Mortality
- Review of Governance performance and KPI's within Divisions
- Essential Standards for Quality and Safety (ESQS) and Registration Compliance
- National Clinical guidelines/standards e.g. NICE, NCE, Royal College reports etc.
- National and Local audit performance
- External assessment and Validation
- Monitoring of safety and service critical action plans
- Implementation of Safety Alerts e.g. NPSA, MHRA, MDA
- Management of SUI and action tracking
- Health and Safety Management
- Maintenance and management of Policies and Strategies
- Scrutiny and review of new [clinical] procedure applications

The above, non- exhaustive, list is factored into an annual plan of work for the BAC and the sub committees that is flexibly managed to adapt to urgent or risk related pressures. Both attendance and agenda subjects are monitored to ensure the committee fulfils its terms of reference.

The care quality commission carried out a responsive review in July 2012, there were concerns around the Never Events. action plans were accepted by the CQC.
The follow up visit in January 2013 resulted in the CQC confirming that improvements and progress that had been made. There are detailed reports on the CQC website in relation to these inspections.

The Trust has continued to strive towards providing a qualitative and safe service. Below is a list of some of the Trust's successes over the last year:

The opening of the Midwifery Led Unit
Redesign of the Health Visiting Service
Robotic Surgery – the first cardiac procedure in the UK.
Patient Safety awards for the care of patients with Dementia
Innovation Award for Infection Prevention
Recognition for the approach to monitoring mortality
Implementation of a sustainable model for seven day working
PEAT scores of Excellent
Reduction in Never Events
70% Reduction in Pressure Ulcers
50% Reduction in Falls causing serious harm
Set the national record for no cases of MRSA

There has been an emphasis on patient feedback and experience, ensuring that the experience at ward level is transferred to the Trust Board directly through patient stories. Patient experience will continue to be a priority throughout the organisation.

1.2 Purpose of the Board Assurance Committee Annual Report

To inform the Trust board of the remit of work activities undertaken by the committee in 2012/2013, and future work development in 2013/2014.

1.3 Board Assurance arrangements in 2012/2013

The BAC structures and functions are detailed in the Trust Integrated Governance strategy which is reviewed annually. The Trust has also had an independent Governance Review in January 2013 to assess the functionality of the Trust and its committees in ensuring that delivery on the Quality Governance agenda was being achieved.
The recommendations from this review where appropriate will be implemented.

The work activity for 2012/2013 is covered in section 1.4 of this report. The committee, via the annual review of its terms of reference, will ensure that its functions remain fit for purpose.

The management of risks in the organisation and the responsibility for those is clear. The Trust Management Team through their respective portfolio's ensuring that risks are managed throughout the organisation. With the emphasis on the "organisation" being a team of individuals from the ward to the board who will take responsibility to ensure that quality and safety are given paramount consideration.

Direct assurance and progress reporting from:

- Information Governance Steering Group
- Health Records Committee
- Education and Training Board
- Research and Development Committee
- Infection Prevention and Control Committee
- Patient Experience
- Compliance committee
- Quality and Safety committee

There is an annual joint meeting of the Audit Committee and the BAC and there is a standing BAC agenda item which ensures a two way feed of information between these committees. There is an overlap in terms of attendance by a non -executive director to both committees.

1.4 Work Activity 2012/2013 and Progress

The Board Assurance Committee has met on 6 occasions throughout the year. There has been a joint meeting held between the Audit and Board Assurance Committees to confirm the Trust's position in relation to the Statement on Internal Control for 2011/2012.

The Committee has reviewed the Board Assurance framework (BAF) at each meeting. There continues to be clear ownership of those risks by the Director who holds this responsibility in their portfolio. The committee appropriately challenges the reasoning and progress that is made against each of the strategic risks. The progress of the BAF is reported to the Trust Board accompanied by the minutes of this committee meeting.
The Trust Board receives a summary of the principal risks and how these are managed in addition to an appendix which details the tracking of changes within the Assurance Framework. The Trust Board receives the tracking of the changes within the Trust Risk register each at month.

As stated above patient safety and experience have continued to be given priority throughout the organisation. Whilst the Trust has made improvements as listed above in the Trusts successes this will continue to be a priority for the Trust.

Leadership Walk Rounds have continued, the emphasis has been on meeting with staff to support them in preventing harm to patients and improve the service that is provided in their clinical area.

1.5 Membership attendance 2012/2013

The membership of the BAC comprises of:

Chair Non-Executive Director (Balsinder Jaspal-Mander)
Non –Executive Director (Jeremy Vanes) also member of the Audit Committee
Chief Executive (David Loughton) Chair of the Preventing Harm Improving Safety Committee
Director of Nursing and Midwifery (Cheryl Etches) also chair of the Quality and Safety Committee and member of the Preventing Harm Improving Safety Committee
Head of Governance and Legal Services (Maria Arthur)
Chief Operating Officer (Vivien Hall -retired) and currently Gwen Nuttall)
Medical Director (Jonathan Odum)

The terms of reference for the committee are reviewed annually. Quorum was set at four core members, of which one must be a non-executive director and one executive director. This expectation was successfully maintained throughout the year. (Appendix 1)

2.0 Relationship with Enabling Committees and the Board

The BAC has a network of specialist and supporting committees as outlined within the integrated governance strategy. All of which follow a line of progress/performance reporting to an overarching forum on regular basis.

The clinical Divisions have established reporting back mechanisms through their clinical leads and governance managers. Their governance scorecard provides a position statement of the local Division's governance performance and clearly identifies exceptions that require action. These actions have an identified lead person and a timescale in which the actions need to be completed. This demonstrates that risk management is embedded in the organisation and there is ownership by front line staff, managers, and the organisation.

Prior to each BAC meeting directors are required to update the BAF risks under their area of responsibility. These risks are addressed at the Executive Management meetings on a monthly basis where the risks are reviewed, updated and assurances documented in relation to any gaps in the management of these risk.

The BAF is presented to the Trust Board to accept the risks. The Board is also informed of other committee activities by receipt of all committee minutes and a summary report which details the key issues. This provides an opportunity for all information to be effectively challenged by the board.

2.1 Risk Management and Assurance Priorities 2012/2013

The priorities for the organisation were to maintain its significant progress on infection prevention and drive for this same excellence in patient experience and care.
The Trust has had no cases of MRSA for 1142 days which is a significant national achievement. The same and additional rigorous standards and controls have also been applied to C. difficile infections within the organisation.
The Trust has reduced its Never Events and has implemented seven day consultant working in the majority of specialities, which should contribute to better patient care.

3.0 Performance Indicators and Outcomes

The Trust continues to address and make progress on areas of non- compliance and has made significant progress. It will continue to support staff in delivering a safe and positive service. The Trust will continue to utilise and report internal and more localised feedback from its users and staff. Precise qualitative and quantitative measures will be identified and formal feedback from stakeholder committees e.g. LINks, Voluntary sector, Specialist support groups can also be engaged.
With the application for FT status this has also included working with Governors.
Following the changes in the NHS, the Trust has already established positive relationships with Clinical Commissioning Groups (CCG) and will now be monitored by the NHS Trust Development Authority (NTDA).

4.0 Challenges, Developments, and Priorities in 2013/14

The challenges and priorities for the next year will be to ensure registration is maintained without conditions, which is an indication that the Trust has maintained the standards expected by the CQC.

The Trust will continue to further develop intelligent reporting on all areas of regulatory compliance and receive the outcome of the Governance review as referred to above

The Trust will be undertaking the assessments for the general NHSLA level three and level two for Maternity. A lot of support has been provided by the Trust staff towards trying to evidence the requirements for these levels, it is hoped that the Trust is successful.

The BAC will receive and review performance reports in order to assure the Board. The committee will need to review measures which show the extent of achievement of the registration outcomes. These outcomes may be linked to existing targets and indicators but others will need to be developed through new metrics and measures. Work has commenced to make links with existing KPI's, CQUIN targets and Quality Account indicators and links with audits, national data collections will need alignment with registration reporting.

Future challenges are around the expectations in relation to greater efficiency savings as faced throughout the NHS, but at the same time ensuring that patient experience and safety remains as the priority and at the forefront of delivery plans across all services.

Appendix 1

Board Assurance Committee Attendance 2012-2013

	April 12	June 12	Aug 12	Oct 12	Dec 12	Feb 2013
Chief Executive (DL)	YES	YES	NO	YES	YES	Yes
CHIEF NURSE OFFICER (CE)	YES	YES	YES	YES	YES	Yes
Head of Governance and Legal - (MA)	YES	YES	YES	NO SH YES	YES	Yes
Non-Executive Director - Chair (BJM)	YES	YES	YES	YES	YES	No
Medical Director (JO)	NO	NO	NO	NO	YES	No
Chief Operating Officer (VH / MOM / GN)	YES	YES MOM	YES	YES	YES	No
Non-Executive Director (JV)	YES	YES	NO	NO	YES	Yes
Quorum achieved	YES	YES	YES	YES	YES	Yes

QUORUM: Four core members must be present, of which at least one must be a NED and one must be an Executive Director.