The Royal Wolverhampton Hospitals NHS Trust

Minutes of the Board Assurance Committee held on the:

Date **20 December 2012**

Venue **Conference Room, Hollybush House**

Time **12:30 – 14:30**

Present:	**Name**	**Role**
	B Jaspal Mander **(BJM)**	CHAIR – Non Executive Director
	J Vanes **(JV) PART MTG**	Non Executive Director -
	D Loughton **(DL) PART MTG**	Chief Executive
	G Nuttall **(GN) PART MTG**	Chief Operating Officer
	C Etches **(CE)**	Chief Nursing Officer
	Dr J Odum **(JO) PART MTG**	Medical Director
	M Arthur **(MA)**	Head of Governance & Legal Services
In Attendance:	**Name**	**Role**
	L Nickell **(LN)**	Head of Education & Training
	Y Hague **(YH)**	R&D Directorate Manager
	S Khunkhuna **(SK)**	IM&T Lead
	Dr M Cooper **(MC)**	Consultant Microbiology
	L Myatt **(LM)**	Patient Access Manager
	Dr B Singh **(BS)**	Chair of Health Records Committee
	T Morris (TM)	*Attending to take the minutes*
Apologies:	**Name**	**Role**

Item No	*It was noted that J Morris (PWC Auditor) was in attendance to observe the meeting to look at scope / refine and improve governance assurance work.*	**Action**
1	**Apologies for absence –** There were no apologies to record.	
2	**Declaration of Interest –** None to note.	
3	**Minutes of Previous Meeting dated 25 October 2012 -** Accepted as an accurate record.	

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4	**Matters Arising from the Minutes & Action Summary**: BJM highlighted actions closed on page 9 of the minutes / action summary and reports which were due for February 2013. Action regarding a pre-board meeting with NEDS regarding cuts to benefits / local Authority discussion remained open.	
5	**Board Assurance Dashboard** MA highlighted the following from the report: There had been a downward trend regarding incidents – Pressure Ulcers, Allergy boxes. The number of mattresses requested by a ward but was not available has decreased. Formal complaints had increased i.e. Clinical treatment / diagnosis and delays. Patient Experience / PALS queries not going onto formal complaints – The timescale is no longer 25 days however data is still recorded and will be measured for future reports. The Complaints Management policy had been revised three months previously however complaints have been taken into consideration regarding complexity. There is no national standard in place and process is determined by need. Serious complaint (Datix 7336) dated June 12 was graded amber but should be green as this was closed off in October. Serious incidents noted under October were still on-going but were not over their timescale. KPI's – These were mainly green. There will be a change regarding indicators as per the SHA. Alerts – one had fallen into the red relating to the Patient Passport and Safer use of Insulin; A pilot has commenced on Ward D16. MA advised that the alert should be closed by the end of December. CE pointed out that the Commissioners felt that the alert had been addressed and that it was just a timing issue regarding detail. The alert would be graded green upon completion of rollout and will flag red for a further two months in the meantime. It was noted that PMR is not an issue however it is an issue nationally. H&S Audit Reports – There is now a revised way of auditing by way of a deep dive type of audit and work activity is being compared and completed along with Risk Assessments. Audits include Corporate areas / Division 1 & 2 and also Community Services. There is a process in place for follow up of ambers.	

	National Guidance: CQC responsive review regarding consent is closed. The CQC have agreed an action plan regarding the Never Event but there has not been a visit since July '12 which is still expected. CE stated that we should challenge this as the action plan is implemented and therefore it should be closed. Francis Report – Phase 2 planned for early next 2013. Mental Health Regulated Activity – The Observations Policy action is still outstanding. BJM stated that there had been developments with the SLA however an end result is still awaited. The members discussed CCG regarding SLA / Mental Health Trust and changes regarding time criteria of six hours as we breach at four hours within A&E. GN highlighted Training AMTC and the Mental Test Score. A service level agreement is being looked at. CE advised that there are two audit reports. A combined action plan regarding training and key trainers trained up is being progressed and led by Lynne Fieldhouse. We are compliant in our processes. Agreement of the SLA issue is still open as this does not provide the service as we would want and has an operational impact. BJM asked that this be kept open. GN to pick up with replacement Lead / including request of specific timescales and update at the next meeting. CE highlighted the MH Policy which is completed but does not work for us and further work that is required regarding our organisational policy. It was also highlighted that A&E utilise a lot of resource. Mental Health provide 24 hour care but then it is up to us to pick up the costs which is the case across the board. BJM asked that timescales be specific in relation to dates in the Dashboard Report. **RESOLVED: The Dashboard Report was noted. GN to pick up action regarding Mental Health with the Lead and report back at the next meeting.**	**GN**
6	**Board Assurance Framework** SK reported that there were 10 risks on the Framework and 27 risks contained on the Trust Risk Register; three red risks under the Financial Director and one new risk – 3277 Failure to meet Catheter Safety CQUIN requirements (red) and 3278 Management of Policies version control, publication and archive (amber) under The Chief Nursing Officer.	

	The following was discussed from the report: **Risk 2570 Inadequate Estates as part of the Transfer of Community Services / WCPCT Provider Services (1 April 2011)** - BJM asked for update on action plans and gaps in assurance further to action dated Sept 2012. DL explained that this was an outline agreement for transfer of properties and provision of services undertaken which required approval from the SHA in order to proceed with Health Centres for GPs. The latter had not happened as yet. It was advised that this was a National issue. Risk 2893 GP Workload / Commissioning tender – A question was raised as to whether there were wider difficulties as it looked out of date and with a limited range of risk. DL advised that this had moved on and the risk was minimal. The financial hit had not been as significant. JV advised that he did not think the risk captured all that was discussed at the Seminar in terms of risk generally i.e. delivery of cytology services across the Black Country. It was therefore agreed for CE to pick up with GN. DL stated that elements of Pathology will be broken down. Risk 2929 Failure to deliver CQUINS – Review of target dated November 2012 which required progress on. To be picked up with Director of Planning & Contracting. BJM stated that discussions had been held regarding previous risks and Never Events and she felt there are action plans, regular reviews and that significant process has been made. The members discussed strategy objectives and overview of specific areas and whether e.g. service line reporting - what this would look like in comparison with last years' data. It was agreed for a one off piece of work to compare data from December 2011 to June 2012 this year and a table to be provided in the report for the next meeting. **RESOLVED:** **Risk 2893 to be picked up with GN.** **Risk 2929 to be picked up with Director of Planning & Contracting.** **Comparison table for data December 2011 – June 2012 to be provided in the report for the next meeting in February 2013.**	**CE/GN** **SK** **CE** **SK**

7	**NPSA / NRLS Report** SK presented the report on comparable information against the rest of the cluster for the period October 11 – March 2012. We are commended as a high reporter. CE asked whether the no of incidents per 100 admissions inclusive of Community and Acute is actually not comparable. A discussion was undertaken and it was advised that for the Acute Trust; we could now be a medium reporter and it would be interesting to compare against a large teaching Trust for example. It was agreed that a report be split into community and for figures to be provided for both the Trust and overall. BJM asked about Safety Walkabouts and incidents highlighted; She asked that regarding closed actions, sections be completed. It was discussed that prior to Directors completing a Walkabout, a report is provided. Training issues and lessons learned was discussed; some incidents will remain open due to investigation. It was therefore agreed that an extra column be added 'if the incident is deemed to be closed'. SK went on to highlight that of 1.8% incidents reported by RWH included some form of person identifiable information; the figure had increased from 1.2% incidents reported April – March 2011. Person identifiable information is uploaded onto Datix and the live system checked. CE asked as to how this is managed and it was advised that the descriptor field is anonymised but more detailed information can be held. The descriptor submitted to the NPSA will be anonymised. Quality Assurance checks are in place and additions can be made. SK also highlighted Table 2 – Degree of Harm. We upload more information regarding No Harm and Near Misses than most Trusts. Page 3; Types of Incidents – Patient accident; there had been 28.40% uploaded across the cluster compared with 18.70% for our organisation. Community / PCT data is included in this. CE asked about infection prevention and percentage which was the same across the cluster and the reasons for this. This was not specifically known however information can be drilled down. Medication incidents were slightly higher regarding administration which SK agreed to check with Pharmacy. BJM asked that we ensure feedback is provided within the organisation e.g. admitted medicine for ingredient. BJM asked that action plans be picked up and monitored. MA advised that incidents are reviewed within areas and are submitted via Patient Safety, Preventing Harm and the Trust Committee processes.	**SK** **SK**

	It was discussed that we cannot say whether we are better or worse and we may see an increase from June. The policy has been amended with regards to doctor errors but we are not counting numbers in the same way as before. Other organisations have not amended their policies. There is an increase in prescribing errors. A report is requested via QSC from Medicines Management Committee. **RESOLVED:** **No of incidents per 100 admissions: Comparable report to be split into community and figures provided for both Trust and overall – SK.** **Safety Walkabouts: Extra column to be added 'if incident is deemed to be closed' – SK.**	
8	**CQC ESQS Compliance Report** MA reported that self-assessments were completed against CQC outcomes and attachment 2 provided a directorate level breakdown. MA pointed out an omission regarding minimum data set. Yellow / amber outcomes will be followed up within the Divisional / Directorate meetings which will feed through to Leads and a second report provided. There were no red outcomes against the self-assessments. MA also highlighted the summary paper provided against the seven amber outcomes: <u>Outcome 2 Consent</u> – DNAR / Policy re-audits will be undertaken for level 3 against harmonising Acute / Community process. <u>Outcome 4 Care & Welfare of people who use services</u> – Graded amber regarding a CQC unannounced visit / moderate concern. An action plan is completed and we await a re-visit. Issues were around audit of the WHO Checklist. An audit will be presented January regarding qualitative data. <u>Outcome 8 Cleanliness and Infection Control</u> – Graded amber regarding Occupational Health and Waste Management. A self-assessment is completed regarding the Hygiene Code. <u>Outcome 11 Safety, availability and suitability of equipment</u> – Audit completed. Issue is around storage and prioritisation. A re-audit will be continued. <u>Outcome 16 Assessing and monitoring the quality of services provision</u> – CQC visit in July related to internal monitoring of the Safety Checklist. <u>Outcome 21 Records</u> – Remained amber. Audits will be followed up. An ICO visit had occurred and we are aware of issues regarding record retention and disposal.	

	MA concluded that a peer review type tool will be developed to observe practice, look at prompts etc. which will feed into KPI's and Performance Reviews. BJM stated that she felt the report provided good timescales. It was ensured that non-compliance is addressed with individuals to ensure feedback and changes have taken place. Directorate level is reviewed by the Divisional Team and Trust level reviewed by Outcome Leads to consider self-assessment and overall compliance. Non-compliant scores are considered against the risk register and movement / progress will be seen. **RESOLVED: The Committee accepted the report which was provided for assurance.**	
9	**Policy Management Framework - DEFERRED**	
10	**<u>BAC Sub Group Reports</u>:**	
10.1	**Infection, Prevention & Control** Dr MC highlighted the summary detailed on page one of the report: He pointed out a typing error of 'November' which should have read 'September' against the first bullet point; MRSA bacteraemia objective breached by a single case. C.Diff remained within its objective. Dr MC added that November performance is better and December data is being looked into. Major projects underway include a study on surgical site infection with universal SSI surveillance for New Cross. Clinical trials will be undertaken. The first month's data reviewed several thousand patients so a year's amount of data will be significant. An IV Team is up and running and work is being undertaken regarding urinary catheters / insertion of care. Compliance with mandatory training; hand hygiene and infection prevention is at its highest. Compliance with the Health and Social Care Act is at around eight out of ten criteria. Detail is contained within the appendix. Dr MC advised that we are making sure that Community and Acute Trust policies are compliant with legislation regarding decontamination. Waste Policy Leads will be updated and the subject is a high priority for discussion at meetings. With regards to Safe Sharps; there is a group in place working with the Health & Safety Steering Group. We have a short timescale to get this up and running of February 2013. Hand Hygiene is around 91.2% and competency aimed for is over 95%.	

	The committee discussed the five moments and escalation of reporting. A report has been submitted to Trust Board. An action plan is provided for TNO areas not achieving green which shows improvements and upward reporting. Targets are an improvement on previous yearly performance. BJM advised that NED's receive reports on an on-going basis. **RESOLVED: The committee accepted the report which was provided for assurance.**	
10.2	**Research & Development** YH reported that over 460 projects are active with targets of around 3000 patients to recruit. The WMNCLRN membership group is down. Gaps include Pharmacy, Radiotherapy and Chemotherapy etc. YH highlighted commercial income and work with the DoH and National research regarding consequences for sites like ours. Funding is on a downturn so it is likely we will see a dip in future planning and there will be a pull back on recruitment targets. YH advised that the portfolio is improved regarding approval of studies of 30 days of completed documentation and R&D actively engage Managers across the Trust. Target timelines have been brought forward and there is an increase in performance. The 40 days target is a national one which has to be implemented locally. There is some success but some patients are too poorly so we cannot meet the criteria for all. YH went on to update that incidents are uploaded onto Datix and highlighted risks contained on the risk register: KPI's - it is catastrophic if we do not meet KPI's. Commercial income is reducing so there will be a link into path building and shared care arrangements. R&D capacity is stretched to its fullest and a meeting is being set up with Estates to discuss. Electronic patient records needs to meet MHRA approval and there is plan for external monitoring. A meeting is also planned with the Medical Director and IT to see how we can move this forward. Currently we have 10 trial monitor visits weekly. R&D is working towards Level 3 NHSLA compliance. Mandatory training is 100% with the exception of Manual Handling which was due to there not being enough places for people to attend training.	

	WMNCLRN Business Planning - A bid to host a new infrastructure is in place and a business plan has been developed. Deadline for notification will be Jan / February 2013. BJM stated that she felt the report covered the main points and it was assured that internal issues of safety compliance are being addressed. All red and amber risks are recorded; however not all are entered onto Datix but work / monitoring is on-going with individual departments. **RESOLVED: The committee accepted the report.**	
10.3	**Education & Training** LN provided the following update from the report: **Outcome 14 QRP** – Results were better or similar to expected. Progress is satisfactory. **NHSLA** – Level 2 achieved for Education & Training criterion. 9/10 criterion passed for Standard 3. Issues are around induction of temporary workers and work is on-going to strengthen processes. Work is also continuing for Level 3. 95% must be achieved against data set topics. There is a robust escalation process in place where we fail to meet mandatory training and emails for evidence are being collated. LN advised there are challenges for 95% compliance against repeat topics. Bullying and Harassment / Infection Prevention Level 1is green. Challenges are discussed within the Project Group. Investigation of incidents, complaints and claims is being followed up with Governance and implementation will be January 2013. BJM stated that regarding mandatory training; this should be on-going and we should not be expecting teams to have to follow up. Issues need to be picked up. LN advised that staff have opportunities and easy access to records. Some topics are new regarding NHSLA standards and we had started off with a baseline of 0. It was discussed that accountability needs to be raised i.e. personal statements, individuals to be accountable and reporting to Managers with escalation to committees on reports where compliance is not met. It was advised that subject leads meet monthly to ensure all is being done and to target low compliant groups. **Postgraduate Medical Education** – Internal visits have taken place in various departments. A mock-up of the WM Deanery visit has been undertaken to prioritise areas and look at any issues as a preventative measure, which the Deanery sees as excellent practice and would recommend to other Trusts.	

	LN highlighted the internal performance Dashboard which has been emailed to all CD's, College tutors and Medical Director. Meetings are undertaken each month with College Leads to go through. LN advised that the action plan has been accepted by the Deanery regarding the visit undertaken in General Surgery (Trauma and Orthopaedics July 2012) and will be monitored via the Post Graduate Education Committee. A report is awaited regarding the Foundation Programme (October 2012). A verbal update has been received and there are no areas of concern. Lessons learned will be monitored via the PGEC; to include timescales, re-audit and good practice shared. For NHSLA and education supervision; we are well ahead of the game. CE stated that education is a strong hand for the Trust regarding NHSLA. BJM asked that we ensure we filter down where necessary. It was advised that Divisional level have to work on via performance reviews. MA raised a question regarding positive work surveys. A discussion was undertaken regarding the score to be re-issued for the first quarter next year. Actual date issued to be checked. The April assessment was not affected by recent visits. Mitigation has been put in place regarding anaesthetics which was the only concern. There were no major issues. JV pointed out that NEDs do not receive a reminder regarding mandatory training being out of date however it was advised that this should tie in with the appraisal process / timescales. **RESOLVED: The Committee accepted the report which was provided for assurance.**	
10.4	**Health Records Committee** LM reported that the harmonised Health Records policy OP07 is now approved and a mechanism will be in place for all acute clinics to operate notelessly by the end of June 2013 which is deemed good practice by the Information Commissioner. The IEPR will be looking at a noteless inpatient working which will be completed by the end of 2013. She went on to highlight the following: **Generic Standards** (developed by Royal College of Physicians) – Trust Training compliance is 89.2% as at the end of October and 94.1% at the end of November. The one off training package was aimed at 4000 staff across the Trust and a proposal is due to go the Health Records Committee on 21 December. **Scanning / Clinic Web Portal** – work is on-going. There has been significant development with the portal and progression will be throughout the next year.	

	The **Referrals Database** has been reviewed / re-written. Correspondence to GP's / electronic work flow - letters are part of the IPR Programme. **Outpatient working** – Some areas are already working notelessly and others are being piloted. JO raised a question regarding management of potential risks relating to gaps when logging incidents when there is no e discharge or notes available, and the impact on patients reviewed in OP1. BS highlighted quality review documentation e.g. discharge summaries, filed notes and that there has to be a way of working to change. Every patient should have e-discharge and the GP summary care record should be available. From January; a business case is developed for all inpatient episodes; sorting, scanning and filing of notes within the portal so staff will be able to click on the admissions date and see an entire record from the last attendance. This will be available from the Spring and support will be provided to staff. The Health Record will then become smaller and from June – August time; only historic records will be kept but it is ensured that these notes will be available. BS stated that he felt there is good clinical leadership. There has been a process of change management and Oncology are working completely noteless with the inclusion of Cannock and Dudley. Work is on-going regarding noteless working for all OPD's and secretaries will be brought on board. CE enquired about risks regarding corporate areas. It was discussed that the process had been agreed at Trust level / with Stakeholders / TMT and Health Records Committee. Process would not have proceeded if it was felt that it wouldn't work. It was advised that whilst this is not a high risk and not contained on the risk register; it is a huge cultural organisational change and whether it is a risk or a risk not to do. LM advised that the risk would be regarding IT failure of the portal within a clinic and how we assess this type of risk. It was advised that we now have a better understanding of our IT infrastructure and a piece of work is being undertaken regarding quality networking. Target is 100% attainment by the end of March. BJM concluded that concerns and issues have been taken on board and would highlight the March deadline for monitoring. **RESOLVED: The Committee accepted the report which was provided for assurance.**	

11	**<u>Issues of Significance for Audit Committee</u>** JV advised he had not attending the last meeting on 13 December but had received a report. Several internal audit reports were completed; Pressure Ulcers, Business continuity, Hygiene Code and the Toolkit. Assurance has been provided on key points. JV highlighted the Bribery Act 2010 and advised that adequate procedures are in place. A wider policy has been required to improve compliance and he would update at the meeting in February. MA asked that the Corporate Governance Policy also be looked at. JV advised he had spoken with the lead for this policy (AS) but would action further. **RESOLVED: JV to speak with the lead for the Corporate Governance Policy.**	
12	**<u>Issues of Significance for Trust Board</u>** **RESOLVED: BJM to provide report to Trust Board. TM to provide minutes.**	
13	**<u>Any Other Business</u>** • **2013 dates were circulated for diaries. BJM forwarded her apologies for the February meeting. JV would be chairing.**	
14	**<u>Date and time of next meeting</u>:** **28 February 2013 @ 12:30 – 14:30** **Conference Room, Hollybush House**	

COMMITTEES OPEN / CLOSED ACTION SUMMARY REPORT – 20 December 2012

ITEM	Action to be taken raised from the meeting	Lead	Carried forward from	Committee Review date	Status
4	Action re pre-board meeting with NEDS regarding cuts to benefits / local Authority / impact on patients – discussion.	BJM/JV	October 2012	**February 2013**	**Open**
5	Board Assurance Dashboard – GN to pick up action re Mental Health with the lead and report back at the next meeting.	GN	December 2012	February 2013	**Agenda Item Open**
6	Board Assurance Framework – CE to pick up risk 2893 with GN. SK to pick up risk 2929 with Director of Planning & Contracting. Comparison table for date Dec 11 – June 12 to be provided in the report for the next meeting.	CE/GN SK SK	December 2012	February 2013	**Agenda Item**
7	NPSA/NRLS Report – No of incidents per 100 admissions – comparable report to be split into community and figures provided for both Trust and overall – SK Safety Walkabouts – Extra column to be added 'if incident is deemed to be closed' - SK	SK	December 2012	Next routine report due June 2013	
9	Policy Management Framework – Deferred next meeting	MA	December 2012	February 2013	**Agenda Item**
11	Issues of significance for Audit Committee – Briary Act – JV to speak with the lead for Corporate Governance regarding link to Corporate Governance policy.	JV	December 2012	February 2013	**Open**

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