The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	27 June 2011
Title:	Board Assurance Committee Annual Report
Executive Summary:	As detailed below
Action Requested:	That the Board note the work activity of the Board Assurance Committee.
Report of:	Balsinder Jaspal Mander
Author: **Contact Details:**	Tel 01902 Email @nhs.uk
Resource Implications:	Nil
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	Joint Board Assurance and Audit Committee April 2011
Appendices/ **References/** **Background Reading**	Appendix 1 BAC Agenda Breakdown 2010/11 Appendix 2 BAC Attendance 2010/11
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 2010/2011

Balsinder Jaspal Mander
Non Executive Director
Chair of Board Assurance Committee
April 2011

1.0 Executive Summary

The last financial year saw a transition at national level with the establishment of the Care Quality Commission (CQC). The Trust successfully ensured compliance with these requirements and achieved registration without conditions.

The Trust underwent a significant NHSLA assessment of its Risk Management systems and processes in December 10 and was successful in obtaining 100% at level 1 in its maternity services although the criteria had changed significantly preventing a level 2 or 3 assessment taking place.
The feedback was positive and timescales were set to achieve level 2 in maternity services in the following year.

There was a review of all the committee structures in November 2010. There were no changes made to the Board Assurance Committee (BAC), but there were changes made to the Quality and Safety Committee. The changes have resulted in a separation of the activities that were covered; therefore there are now two additional committees which are the Compliance and Policy committees.

Through the BAC and the supporting subgroups, 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 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 Trust reviewed the Integrated Governance Strategy to ensure that its arrangements would achieve the new requirements of regulation and safety standards. There was an emphasis on maintaining and improving rigour in established processes in order to achieve the regulatory, quality and safety outcomes which are now appropriately triangulated by user experience/evidence.

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 2010/2011, and future work development in 2011/2012.

1.3 Board Assurance arrangements in 2010/2011

The BAC structures and functions are detailed in the Trust Integrated Governance strategy which is reviewed annually.
The work activity for 2010/2011 is covered in section 1.4 of this report. The committee, via annual review of its terms of reference, will ensure that its functions remain fit for purpose.

Committee reporting has been enhanced by the instigation of additional quarterly reporting from Quality and Safety Committee (QSC) to the Trust Management Team on operational risk issues; and additional reporting from QSC to the BAC through a dashboard of issues and exceptions for monitoring. The dashboard covers:

- SUI action tracking
- Serious complaint action tracking
- Incident/complaint trend monitoring
- Complaint response and KPI performance
- Safety alert monitoring
- Health and Safety management performance
- Governance KPI Performance
- Internal audit report monitoring.

Direct assurance and progress reporting occurs 3 to 6 monthly from:

- Information Governance Steering Group
- Health Records Committee
- Education and Training Board
- Research and Development Committee
- Infection Prevention and Control Committee
- Estates Strategy and Sustainability Board
- Patient Experience
- Mortality Committee

In addition to the annual joint meeting of the Audit Committee and the BAC, in 2010/2011 a standing BAC agenda item was added to ensure 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.

The committees have continued to develop their reporting and intelligence mechanisms to provide reliable and timely assurance reports to the board in line with its terms of reference.

1.4 Work Activity 2010/2011 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 2010/2011.

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 Internal Auditors reviewed the governance arrangements for: Learning Disabilities, Adult Safeguarding, Mental Capacity compliance, Divisional Governance and Risk Management, Board Assurance Framework, CQC registration – ongoing monitoring, recurring themes and also reviewed the progress made in relation to the previous safeguarding children audit report.
The conclusions drawn were that the Board could take substantial assurance that the controls upon which the organisation relies to manage the risks were operational and effective and significant progress had been made and future action plans were in place to ensure continuous improvement.

The business of the committee has been to receive the reports in relation to the areas identified in 1.3**.** (Appendix 1)

The contents of the reports and the schedules for the reporting of the above have been reviewed throughout and further defined during this period of activity to ensure that the committee continues to receive qualitative information.

Patient safety and experience have continued to be given priority throughout the organisation. The emphasis has been to ensure that direct patient experience is brought to the attention of the Board. The Board receives patient stories and regular detailed reports on complaints. The patient safety agenda has made considerable progress, which has continued to see excellent progress in infection prevention. The focus has been to improve patient care and experience this has been evidenced by the implementation of robust action plans through the Preventing Harm Improving Safety sub committee. (This is chaired by the chief executive and reports to the QSC). For example the Trust has seen the long awaited implementation of the upgraded PAC system and the Vital Pac system.
The Trust has implemented the recommendations from the Francis enquiry and the Airedale report recommendations; the monitoring of these recommendations has been through the BAC.

There has also been a further review of the Leadership Walk Rounds, where 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. The initial results have been positive and will continue to be part of the planning and drive to ensure that there are continuous improvements; and that the identification and management of risks and the delivery of a quality service is owned by all staff in the Trust. The walkabouts will also be extended to outside office hours.

1.5 Membership attendance 2010/2011

The membership of the BAC comprises of:

Chair Non-Executive Director (Balsinder Jaspal-Mander)
Non –Executive Director (Jeremy Vanes, previously Stephen Bright) also members of the Audit Committee
Chief Executive (David Loughton) Chair of the Preventing Harm Improving Safety Committee
Director of Governance (David Churchill)
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)

The terms of reference for the committee were reviewed in April 2010 and again November 2010. 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 2)

2.0 Relationship with Enabling Committees and the Board

The BAC operates above 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 a 3 to 6 monthly basis. Intelligence on risk and other priorities is fed either directly to BAC or indirectly via the QSC.

The committee reviews and maintains the currency of the BAF at every meeting (bi monthly). All sources of intelligence and monitoring via subgroups and the annual work plan feed into the framework.

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 number, red BAF and operational risks and changes are presented to the Board to accept on a monthly basis. The Board is also informed of other committee activities by receipt of all committee minutes and a summary report (as appropriate) for issues identified for escalation. This provides an opportunity for all information to be challenged by the board.

2.1 Risk Management and Assurance Priorities 2010/2011

In 10/11 the driving priorities for the organisation was 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 the 19th consecutive month. The same and additional rigorous standards and controls have also been applied to C. difficile infections.
Through the advancement of establishing real time patient feedback which would help to develop positive practice and performance in what fundamentally really matters to patients.

The Trust has continued to be compliant in most areas but recognises the improvements it still needs to make in relation to information governance.
The Trust, through the national Transforming Communities agenda, took over responsibility of some of the core services from the provider arm of the PCT. This integration has been a positive move and the benefits realisation plans continue to be developed. This however may present further challenges, but to date risks have been identified and there are action plans in place to mitigate against these risks. Further challenges will inevitably arise from the planned changes from the white paper "Liberating the NHS".

3.0 Performance Indicators and Outcomes

The Trust has as stated above addressed 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 will also include working with Governors'.

The above will be considered in the terms of reference and work plan for the committee in 2011/2012.

4.0 Challenges, Developments, and Priorities in 2011/12

The CQC have stipulated that each registered organisation will be inspected at a frequency of between 3 months and 2 years depending on their established compliance and risk profile. The methods for measuring and monitoring performance will include:

- The development of a quality and risk profile (QRP) for each organisation which will be continually monitored by the assessors. This profile will be informed by numerous bodies accountable for measuring, assessing, and reporting standards of performance e.g. HSE, NHSLA, NPSA, Staff, and National Patient Surveys. The profile will be shared with s for their internal redress.
- The CQC have developed a provider compliance assessment (PCA) tool which allows organisation to maintain an up to date self assessment of their compliance to the regulations. This can be requested by the CQC assessor as part of initial investigations into an alert or concern in the organisations' risk profile.
- The CQC will also commission a number of themed reviews on various subject areas. All appropriate organisations will be mandated to take part and contribution may be in the form of raw data submission or full audit in an area.

The Trust will need to develop swift and intelligent reporting on all areas of regulatory compliance. A live record of its compliance and evidence is vital alongside an accurate and responsive performance framework. The Trust has purchased an IT system (Performance Accelerator) to support compliance management and reporting at all levels of the Trust. The roll out of the system has commenced with CQC standards and will be applied to other compliance drivers i.e. NHSLA, Information Governance etc. 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.

The Trust delivers a high standard of services and continues to identify and manage risks to the quality of care as stated above.

As stated above the future challenges are those highlighted in the white paper with the challenges that will be faced with the expectations around greater efficiency savings 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

BAC Agendas April 2010 - Feb 2011	April 2010 Joint committee	June	August	October	December	Feb 2011
Trust Board Executive Summary			√	√		
Board Assurance Framework	√	√	√ incl financial risks	√	√	√
NPSA NRLS Organisational Feedback		√			√	
Governance Strategy						√
Review of Committee Structure /						√
Compliance Management Update						√
Patient Experience						
STEIS/SUI Report (Action Tracking)		√		√		√
Dr Foster		√		√		
S4BH Final compliance position	√Verbal Update					
Risk Management Trends Analysis						
Board Assurance Dashboard	√	√	√	√	√	√
Trend Registry Report	√				√	
CQC Registration – Regulated Activity	√		Briefly discussed	√	√	√
CQC Registration – Ongoing Monitoring			√			
NICE Guidance						
Perinatal Mortality						
Francis Report			√	√	√	√
Bentley Jennison Reports						
Learning Disabilities / Mental Capacity Act	√	√				
Recurring Themes	√					
Safeguarding Children Progress		√				

BAF Audit Report			√			
SUB GROUP REPORTS:						
Information Governance / toolkit sign off!		√		√		√
Research & Development			√			√
Education & Training		√			√	
Infection Control		√			√	
Patient & Public Engagement Partnership		√				√
Estates & Development		√			√	
Health Records Committee	√				√	
Mortality Committee						√
Oncology & Haematology Directorate Quality Assurance						
AUDIT (issues of significance) – Internal Audit Plan / Opinion	√Draft					
Q&S minutes	√	√	√	√	√	√
Audit Committee – Activities 09/10	√					
BAC – Activities 09/10	√					
Statement of Internal Control	√Draft					
TOR Review – BAC / Audit Committee	√					
Annual Report						
Draft Counter Fraud Workplan	√					
Local Supervising Authority Annual Report to NMC					√	
Airedale Report Recommendations						√
HSE Visit						√

Board Assurance Committee Attendance 2010-2011 **Appendix 2**

	April 10	June 10	Aug 10	Oct 10	Dec 10	Feb 2011
Chief Executive (DL)	YES	NO	NO	YES	NO	YES
Governance Director (DC)	NO	YES	YES	YES	YES	NO
Director of Nursing & Midwifery (CE)	YES	YES	NO	YES	YES	YES
Head of Governance and Legal - Acting (MA)	YES	YES	YES	YES	NO	YES
Non Executive Director - Chair (BJM)	YES	YES	NO	YES	YES	NO
Non Executive Director (SB)	YES	NO	YES	N/A	N/A	N/A
Chief Operating Officer (VH)	YES	YES	YES	YES	NO	YES
Trust Secretary (CW)	NO	N/A	N/A	N/A	N/A	N/A
Non Executive Director (JV)	N/A	N/A	N/A	YES	NO	YES

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