

**THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST**

**MINUTES OF THE MEETING OF THE BOARD ASSURANCE COMMITTEE  
THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST HELD ON  
THURSDAY 17 DECEMBER AT 12:30 IN  
THE CONFERENCE ROOM, HOLLYBUSH HOUSE**

- PRESENT:**
- |               |   |
|---------------|---|
| Mr S Bright   | Non Executive Director –<br>Acting Chairman |
| Mr D Loughton | Chief Executive                             |
| Ms C Etches   | Director of Nursing and Midwifery           |
| Mrs M Arthur  | Head of Governance & Legal Services         |
- IN ATTENDANCE:**
- |                      |   |
|----------------------|---|
| Mr A Edwards (part)  | Chairman  |
| Mr B Miller (part)   | Medical Director                                  |
| Mr S Khunhuna (part) | Acting Governance IM&T Lead                       |
| Mr G Penn            | Director of Estates & Development                 |
| Dr M Cooper (part)   | Microbiology Consultant - Infection<br>Prevention |
| Mrs Y Hague (part)   | R&D Directorate Manager                           |
| Mr J Samra (part)    | Consultant Gynaecologist (Chair - E&TC)           |
| Mrs Nickell (part)   | Head of Education & Training                      |
- APOLOGIES:** Mrs B Jaspal-Mander, Ms V Hall,

		<b>ACTION</b>
<b><u>2.0 MINUTES OF THE MEETING OF THE BOARD ASSURANCE COMMITTEE / ACTION SUMMARY UPDATE HELD ON THURSDAY 8 OCTOBER 2009</u></b>		
	SB requested that the minutes be typed up in the same style as Trust Board.	<b>TM</b>
2.0	<u>S4BH / Mental Health Issues</u> – CE provided an update to the committee regarding patient learning disabilities and advised that following an audit report there were significant actions to implement which was being led by HW – Deputy Nurse Director. CE added that discussion had been undertaken to challenge the recommendations and this would be taken forward by HW.	
	<b>Resolved that:</b>	
	<b>1. CE and SB to discuss outside of the meeting.</b>	<b>CE/SB</b>
3.2	<u>Perinatal Mortality</u> – CE advised she had contacted the SHA and put her request in writing. Once a written response had been received she would distribute to the BAC members.	<b>CE</b>
4.2	Incident 9775 / Policy document – MA advised that the local policy for Biopatch Zonex (Renal Unit) had been completed and was awaiting ratification. HW – Directorate Manager (Div 2) was taking forward and action could now be closed.	

### **3.0 MATTERS ARISING FROM THE MINUTES**

There were no further matters arising from the Minutes.

### **4.0 REPORTS FOR APPROVAL / ACTION OR DEFERRED FROM PREVIOUS MEETINGS**

#### **4.1 BAC DASHBOARD**

MA advised that this was an issue / exceptions report and highlighted the following:

##### **SUI Tracker –**

Red incident 38096 / working with VTE to develop policy. CE advised that this would be picked up at the PSG Meeting and that the lead for the strand of work of the PSG had stood down. BM stated that there had been two previous chairs of this committee and they were looking at appointing a new chair, possibly an Orthopaedic Surgeon as this was an area of concern with regards to implementing assessments. Work is ongoing in EAU. BM agreed to chase up the policy which was completed in draft, and that a chair would be agreed at the PSG Meeting.

Amber incident 50809 / Biopatach and Zonex / work had started with the splitting of notes and an update would be picked up in the next report.

**Trends monitoring** - improved from last year.

**Patient experience** – 89% compliance. PET programme ended November. Paper being completed by Deputy Nurse Director. One new amber complaint regarding appointments.

**Governance KPI's** – awaiting Q2 report.

**H&S** largely good and work continues RA's, inspection and compliance work. Increased number of CAS alerts in December.

SB enquired about corporate risks. MA advised that there had not been the same focus on corporate divisions as with clinical divisions and we needed to bring corporate areas in line with reporting. MA and CE to pick up in one to one meetings.

MA advised that Bentley Jennison reports highlighting fundamental actions would be featured in this report for monitoring.

- **The committee noted the report.**

**Resolved that:**

- 1. VTE policy to be chase up and chair of PSG to be agreed.**
- 2. MA / CE to discuss corporate resources.**

#### **4.2 NPSA / NRLS REPORT**

SK provided an update for the period Oct 08 – March 09 and highlighted that the Trust reports on average 540 PSI's per month and that it is in the top 10% within the cluster of reporting organisations. He added that 1.3% of incidents reported in this period included person identifiable

**BM  
MA/CE**

information and that the Trust encourages reporting of near misses. The committee discussed under reporting of medication incidents and it was felt that we were confident that we were reporting serious incidents but as to whether every medication error was reported would depend on definition.

SK explained for example, that Chart 2 – Incident Type shows documentation higher in the cluster because of W&C reporting misfiled documentation incidents and it was pointed out that in some areas we are higher or lower in the category, and audits are carried out to measure these.

CE enquired as to where we would pick up patient allergies if the box is not completed on the drug chart and it was answered that this would come under 'Documentation incomplete'.

- **The committee noted the report.**

#### **4.3 BOARD ASSURANCE FRAMEWORK**

SK highlighted the following points from the report:

Risk 1501 / 1502 agreed to be downgraded. There were four reds and one amber. Risk 1320 – Results of diagnostic tests had been amended and this would be shown in the next report. Many actions had been closed. CE added that not all Radiographer posts had been recruited and when in place this would help with reporting.

Risk 1739 – Failure to develop service line reporting, would be cross checked at the Directors meeting to consider.

SB highlighted Risk 1102 (red) 'risk after actions', and it was advised that this was amber.

CE also added that we needed to focus on fluidity of Divisional Risk Registers and link into the Board Assurance Framework.

**Resolved that:**

**1. Report to be taken to Directors Meeting Wednesday 23/12/09 for consideration and then to Trust Board in January 2010. Report due back at BAC February 2010.**

CE

#### **4.4 COMMITTEES SIX MONTHLY REPORTS**

##### **4.4.1 RESEARCH & DEVELOPMENT**

YH gave a detailed outline of assurance that R&D support regarding research and innovation within the Trust. She advised that R&D do not work in isolation and work with other services before trials are agreed. Quality is not compromised and staff are supported to follow competency levels. R&D are a patient recruitment centre for trials and are accountable for maintaining patient safety. YH added that R&D are a leading centre in Europe for patient tracking and SAE's are linked to patients and trials and are monitored locally. She highlighted the process of investigations and stated that they expect to see a lot of SAE events

due to the nature of the work. These are recorded and trends monitored. YH concluded that they were confident robust systems were in place within R&D.

The committee discussed new techniques and it was advised that these come under the QSC process and a specialist group put together where necessary. Ethical approval falls under the R&D process. CE added that audit processes are clear regarding patient outcomes and patient adverse events. Regarding consent, the person must be competent and trained to undertake a procedure.

SB enquired about audit and governance processes within R&D and it was answered that R&D are a recruitment centre and are monitored externally on a quarterly basis and that there is a qualified internal auditor on site. There will be a lead trained up within the department to monitor against other trusts and SOP's are in place.

Regarding datix, a clinical nurse lead will liaise with the consultant and check whether incidents are related to a trial.

- **The committee noted the report.**

#### **4.4.2 INFORMATION GOVERNANCE**

BM informed the committee that the Information Governance Toolkit (IGT) is the tool which the organisation uses as a self certification method for notes. A report had been forwarded to TB and further improvements had now been included in this report. 70% is required for a rating of green and we are currently on 69% but BM was confident that this would be achieved.

BM also highlighted the Pseudonymisation Implementation Project (PIP) which has become part of the toolkit and was about how we hold patient data and control distribution to outside bodies. He pointed out App 1 which detailed the scores:

**120** – Joint work ongoing with HR/IT. TNA carried out and we should achieve level 2 in the next few months. Level 3 requires evidence in place.

**121** – KS (Finance Director) is the appointed SIRO and is to undergo Information Governance Training. Level 2 should be achieved by the end of the financial year. MA was asked if the registration application level could be checked. It was agreed this would be done by the end of January.

**322** – related to 120 / smartcard issues which were nearing completion.

**601** – A lot of work undertaken to achieve level 1. Records Management Strategy approved through the Board and additional work to be carried out.

The committee discussed Caldicott and SIRO and who would take control of work involved. CE pointed out that the governance element should be kept together. To be discussed further.

**Resolved that:**

**1. BM to speak with KS to discuss this further.**

**BM/KS**

**4.4.3 INFECTION PREVENTION & CONTROL**

Dr M Cooper provided a brief rundown of the work of the Infection, Prevention and Control Committee.

The committee debated what should be reported to BAC and being mindful not to repeat the detail of what is reported to QSC and other Sub Committees. It was discussed that BAC should see the work of the committee to improve compliance and assurance in a six monthly report. Mrs Arthur highlighted continued compliance regarding registration and it was confirmed that minutes of IPCC go to TMT & TB regularly and there was a process in place to satisfy the Hygiene Code. Evidence to be signed off Jan 2010. Mrs Arthur pointed out that although already registered, Hygiene Code to be checked and a statement of position was required regarding Infection Prevention for registration application. It was agreed that Mrs Arthur and Dr M Cooper to meet to discuss work regarding this and a separate report for Trust Board if re-registration was required.

**Resolved that:**

- 1. Registration Application Report to Trust Board Jan 2010.  
Agreed for six monthly report of IPCC to BAC.**
- 2. MA and MC to produce Hygiene Code Report / statement.**

**MC**

**MA**

CE also highlighted that work was ongoing with the SHA to benchmark data on other infections against organisations and National Target.

**4.4.4 EDUCATION & TRAINING**

LNI advised that there was some duplication within her report. Focus had been on domains that they were assessed upon. The Trainee PMETB results had been released which showed that we were doing well with respiratory medicine but not so good in other areas. LN stated that she would value information required for future reports.

SB enquired about external validation and it was answered that there are good robust governance processes in place i.e rolling programme for Deanery visits and an Education Board in place.

The committee went on to discuss annual reporting on quality of training and process via Education sub groups, committees and appraisal, score card and delivery in order to meet external standards. LN pointed out that regarding trigger / random visits and monitoring of PMETB, she was confident for their meeting in January with the Deanery. Regarding feedback processes, junior doctors forums' are measured and will be made more robust in order to take ownership.

CE advised that the BAC would want to be assured that plans are in place, mechanisms monitored, an annual plan in place to show how the agenda is linked to governance and how this is fed into training. That there is a process for reviewing and future implications are included regarding risks, governance and re-validation. There should not be

duplication of the work of QSC but co-evidence provided. MA also highlighted that reporting for such corporate areas was part of the role out from the Integrated Governance Strategy and formed part of S4BH, NHSLA declarations and sign off.

- **The committee noted the report.**

#### **4.4.5 PATIENT & PUBLIC ENGAGEMENT PARTNERSHIP**

HW presented the report produced by DE and highlighted the agenda, initiatives and work ongoing over the last six months of the Patient and Public Engagement Partnership.

CE pointed out that focus was on engagement and this group replaced the old PPI Forum. CW was now involved in communication and public involvement and a newsletter is regularly communicated. The committee discussed information not sourced and future structure of the group to associate risks. MA added that future reports would pick up requirement of new registration standards. It was agreed for the department to address issues and provide assurance to BAC to take forward.

**Resolved that:**

- 1. MA to work with HW.**

**MA / HW**

#### **4.5 ESTATES & DEVELOPMENT – INTEGRATED GOVERNANCE REPORT**

GP provided an update on the new groups formed within Estates & Facilities and advised that risk registers are fed into Datix. MA added that the risk register monitored will be captured in the corporate areas within the divisional scorecard and main dashboard.

The committee discussed what type of report would be expected on a six monthly basis to show that the assurance process is working i.e. exception reports to ensure major risks are highlighted to BAC. The committee would wish to be assured that Estates & Facilities strategies are approved, policies are in date and annual reports are monitored against S4BH registration. Main AP's to be monitored and implemented, department / strategic plans to include governance arrangements, requirements of governance structures are in place and show that delivery of risk management is robust.

The committee also discussed the capital spend programme and business case process and via what routes these are signed off. GP advised the process is via 1/ service stream, 2/ workforce stream and 3/ financial stream.

MA highlighted that reporting was discussed at two levels operational relating to the risk management performance at department level and at a more strategic level for assurance. The QSC would review operational risk management and the BAC would review higher level assurance to incorporate the new registration requirements. It was agreed for MA to work with GP for future reports.

**Resolved that:**

- 1. MA to work with GP.**

**MA/GP**

**4.6 2010 COMMITTEE MEETING DATES**

SB requested that the February date be checked against the Audit Committee date.

**TM**

CE suggested the April joint meeting venue be changed to accommodate everyone and it was agreed that the board room in the new Clinical Skills & Corporate Services Centre be booked.

**5.0 BENTLEY JENNISON REPORTS**

MA provided the following updates:

**5.1 STANDARDS FOR BETTER HEALTH – MARCH 09**

Actions closed.

**5.2 RECURRING THEMES – JUNE 09**

Actions were in hand. Those few overdue were awaiting an upgrade on datix before action tracking could be fully functional.

**5.3 RISK MANAGEMENT PROCESSES IN DIVISIONS – SEPT 09**

No recommendations.

**5.4 SAFEGUARDING CHILDREN – SEPTEMBER 09**

Two actions due at the end of the year as yet not complete. Policy and JD review by the JHSCC. This would be addressed in a separate meeting in January 2010. TOR had been reviewed and agreed.

**MA**

**6.0 ISSUES OF SIGNIFICANCE ARISING FROM THE AUDIT COMMITTEE**

There were no further issues to discuss.

**7.0 QUALITY & SAFETY COMMITTEE MINUTES (FOR INFORMATION)**

**7.1 OCTOBER 09**

CE highlighted 4.3 Mid Staffs Report, management review of current emergency services in A&E and EAU. Newly appointed Nurse Practitioners will work on operational pressures.

Appointment set for Radiographer.

**7.2 NOVEMBER 09**

CE highlighted:

4.1 New procedure application / technique of Laser Prostatectomy within the organisation.

5.3 Central Alert System – There was priority focus to reduce overdue alerts.

**8.0 FOR NOTE NEW EXTERNAL REPORTS**

There was no new external reports.

## **9.0 ANY OTHER BUSINESS**

There was no other business to discuss.

## **10.0 DATE AND TIME OF NEXT MEETING**

Thursday 25 February 2010 at 12:30, Conference Room, Hollybush House

## **COMMITTEES OPEN / CLOSED ACTION SUMMARY REPORT – 17/12/09**

	<b>Action to be taken raised from the meeting</b>	<b>Lead</b>	<b>Carried forward from</b>	<b>Committee Review date</b>	<b>Status</b>
2.0	S4BH / Mental Health Issues - Discussion	CE / SB	October 09	-	Open
3.2	Perinatal Mortality – written response to be distributed to BAC	CE	October 09	-	Open
4.1	VTE policy / PSG Chair to be agreed/approved	BM	December 09	February 2010	Open
	Corporate resources to be discussed	MA / CE			Open
4.3	BAF Report to Directors meeting December / TB January 2010	CE	December 09	February 2010	Closed
4.4.2	Information Governance – Caldicott / SIRO work to be discussed.	BM / KS	December 09	June 2010	Open
4.4.5	Patient & Public Engagement Partnership report development	HW / MA	December 09	June 2010	Open
4.5	Estates & Facilities report development	GP / MA	December 09	June 2010	Open
4.6	February BAC dates to be checked against Audit Committee	TM	December 09	-	Closed
	Clinical Skills & Corporate Services Centre Board Room to be booked for April joint meeting				Closed