

Minutes of the Integrated Risk & Governance Committee (IRaGC)
Thursday 13 January 2011
9:00 – 10:00 am, Executive Meeting Room (Spice of Life)

Present:

Mahdi Hasan	Non-Executive Director (Chair)	MH
Jan Filochowski,	Chief Executive	JF
Chris Green	Non-Executive Director	CG
Sarah Connor	Non-Executive Director	SCo
Colin Johnston	Director of Patient Safety & Medical Director	CJ
Patricia Duncan	Ass Director of Governance and Risk	PD
Sarah Wiles	Director of Strategy & Infrastructure	SW
Eric Fehily	Associate Director of Estates	EF
Howard Borkett Jones	Assoc. Director of Medical Education	HBJ
Tahir Bhatti	Divisional Director for Surgery & Anaesthetics	TB
Anthony Divers	Divisional Director of Clinical Support	AD
Martin Keble	Chief Pharmacist	MK
David Griffin	Divisional Director of WACS	DG
Robin Wiggins	Pathology -Consultant Microbiologist	RW
David McNeil	Director of Communications & Corporate Affairs	DM
Natalie Forrest	Director of Nursing	NF
Chris Pocklington	Director of Delivery	CP
Nick Evans	Director of Partnerships	NE
Mark Vaughan	Director of Workforce	MV
Kyle McClelland	Assoc. Director of Hotel Services	KMC
Anna Anderson	Director of Finance	AA

In Attendance

Pamela Mudie	PA Clinical Governance & Risk	PM
Frances Stratford	Asst. Director Infection Prevention and Control (Asst. DIPC) FS	
Katrina Walker	Infection Control CNS	KW

Item		Action
10.46	Apologies for Absence	
	Mark Jarvis, Mike Clements, David Griffin	
10.47	Minutes of the last meeting on 18th November 2010	
	The Minutes of the IRaGC meeting on 18 th November 2010 were approved subject to David McNeil being added to the attendance list.	
10.48	Matters Arising & Tracker	
	Tracker was discussed and updated. 10.31 <u>The Big Ask</u> – no update 10.31.3 <u>AAU Risks</u> CJ, who was leading on this issue with CP, noted this has not been to Board and a report covering the following was to go to the next Board meeting : <ul style="list-style-type: none"> o Capacity Issues relating to transfer of patient from AAU o Management of patients when capacity reached o Staffing issues 10.33 <u>CQC Compliance</u> (Estates) SW reiterated that the concerns relating to maintenance of temperatures and	

	<p>potential link to admissions to SCBU had been addressed. PD advised that the position was clarified in the November minutes but that a response was still awaited from the CQC to the letter notifying of minor concerns in relation to Estates. PD noted that NF had invited the local CQC assessor for an informal visit which will take place on 28th January 2011.</p> <p><u>10.33 CQC Compliance (Medical Devices Management)</u> EF circulated a paper which outlined that good progress has been made on medical device training over the past 5 months to ensure the Trust is meeting NHSLA and CQC compliance.</p> <p><u>10.38 Patient Safety Risks:</u> Letter is to be drafted to all Chairs and the action will be closed once it is sent.</p> <p><u>10.40 Rotational review of Divisional Risk Registers</u> This should be closed off the tracker and a schedule for review set up.</p> <p><u>10.42 Risk Management Strategy</u> PD noted further amendments have been made to reflect concerns raised by SCo in relation to the defining of the Trust's risk appetite. PD noted she had also received further comments from AA and these will be incorporated into the final version. SCo stated she felt the updates reflected the risk appetite very well and it was agreed that subject to these amendments the Strategy will be agreed by the Committee and should be presented for ratification at the January Board meeting. (<i>Post meeting note:</i> this was also agreed by the Audit Committee meeting, which took place immediately after this meeting).</p> <p><u>10.43 NHSLA Level II Assessment</u> NE noted the enhanced requirement in relation to Risk Management Training introduced in the updated standards. It has been agreed that the Governance and Risk team will manage the administration of risk training because of difficulties using the Workforce database to identify target groups. It was noted that the Board requires an update. PD advised of the need to deliver formal training to senior managers and proposed this should constitute all those managers attending the Chief Executive's monthly meeting. This was agreed. It was also noted that this meeting will incorporate, later in the agenda, a development session for Committee members facilitated by the Chair, MH.</p>	<p><i>PD</i></p> <p><i>PM</i></p> <p><i>To Board for ratification</i></p> <p><i>PD/GS</i></p>
10.49	Board Assurance Framework (BAF) – Progress Update	
	<p>CJ requested that the following risks are escalated to the Board Assurance Framework:</p> <ul style="list-style-type: none"> Seasonal Flu – In light of the recent issues in the management of this year's dominant strain, including Occupational Health, staff and service preparedness, CJ felt this should remain for at least 12 months. NHSLA accreditation – CJ felt this is an important element in meeting strategic objectives because of its impact on CQC confidence and the Quality and Risk Profile, the Trust's reputation and the financial implications set out in the previous meeting. It is vital the Board supports the work to achieve Level II and work towards to Level III. <p>PD reported that DM had considered escalating risks associated with Mandatory Training however the risk assessment resulted in a score of 9, with work underway and addressing the issues. It was felt this would not be appropriate for escalation to the Board Assurance Framework.</p> <p>PD noted the format of the BAF and wished to enhance it noting that this is hampered by not having the Risk Management module of DATIX. This creates difficulties for those working with risk registers as well as the BAF as the information has to be cut and pasted from the DATIX system. The deputy chair</p>	<p><i>PD discussing with MH</i></p> <p><i>PD to obtain</i></p>

	asked for costings on current and new processes.	
10.50.	The Big Ask (standing item)	
	It was agreed that there are no new/emerging risks to do with the Big Ask.	
10.51	Risk Case Study (Committee Development Session)	
	<p>MH introduced the session asking that the Committee consider how the Trust can look for opportunities to progress to a higher level of excellence in risk management. He presented a case study of the recent infection control issues, prepared with the help of Frances Stratford and Katrina Walker of the Infection Control Team.</p> <p>MH wished not to focus on the detail of the incident but to use it as an opportunity to learn from the incident. He suggested the Committee focus on looking at the issue from the perspective of:</p> <ul style="list-style-type: none"> • Creating a sense of shared goals across divisions • Intervention by Divisional staff if action from other divisions threatens a Trust goal • Cross Divisional Approach • Opportunity to create a culture of challenging, encouraging and appreciating <ul style="list-style-type: none"> ○ JF felt these are pertinent questions and that it should be a reflective and thoughtful discussion. ○ One issue that emerged from the investigation of the cluster infection was that a decision had been made with withdraw deep cleaning machines but that not all stakeholders were involved in this decision. The reasons related to a combination of factors but specifically that the costs of maintaining the machines set against the utilisation of the machines led to a value for money decision. ○ The impact of this decision was that the machines were no longer deployed. The investigation revealed that prior to this decision, there had been no planned programme of ward cleaning and when cleaners attempted to clean wards they were usually not able to do so because of access. ○ The outcome resulted in the requirement for a planned programme of steam cleaning agreed between Medirest and the wards. The recommendation emphasised the responsibility of both Medirest and wards to escalate if the cleaning schedule is not carried out. ○ The key learning from this case study was the importance of recognising that decisions have consequences and to ensure all possible consequences (including potential risks) are understood, decisions need to be the product of stakeholder involvement. ○ The case study reflected the importance of understanding who the stakeholders are in protecting a Trust objective to avoid the issue being viewed purely as a local operational issue. ○ CJ noted that any changes in procedures, particularly cross ward/generic rather than specialist must be understood from all divisional aspects. ○ Another example was cited by NF, of the World Health Organisation (WHO) surgical checklist which is now required to be used for all theatre/surgical procedures. This represents an approach which gives all staff involved (surgeon, nurse, ODP) a chance to voice any concerns before surgery begins. This checklist was devised to address the risks of performing surgery on the wrong site – this has been an international problem with high profile examples of what can go wrong (eg removal of health kidney instead of diseased kidney). ○ MH said this is an excellent example but cautioned that implementing such a culture beyond the related functions eg surgical, nursing and anaesthesia becomes a greater challenge when involving non clinical functions, such as 	<p><i>NF to take to Matron's meeting & report back</i></p>

	<p>Estates and Facilities and Hotel Services.</p> <ul style="list-style-type: none"> There was general discussion about tensions in some situations of following processes and the need to take initiative under pressure. Consequences have to be considered and results monitored. All staff need to have the confidence to highlight problems and be appreciated for it. Junior doctors are a good case of this as they can often see the problems but do not feel encouraged to act on them. SCo suggested talking to other organisations to see how they build flexible teams but JF felt this might be too ambitious as a first step. PD suggested taking it to the team working on Leadership Development in the organisation as team values and behaviours are important aspects of leadership. MV suggested results from staff survey should feed into development programmes. NF to take this to the Matrons Meeting and do a 10-minute feedback at the next CQuaC. MH emphasised that the case study was used to look at the principles rather than to focus on the particular issues which had been addressed and processes developed. JF said this is not just about cleaning but it should be based on the fact that this is an adverse event causing patient harm in a particular environment. MH concluded the discussion with the observation that its quality and participation by committee members was very encouraging and that the session should be taken as a first step to maintaining and broadening such discussions and learning opportunities in order to better understand the need to embed risk management in all decisions. 	
10.52.	NHSLA – reporting via monthly DSG and BISE – update noted in CQuaC minutes.	
10.53	<p>Reporting Committee Minutes</p> <p>No reporting committee minutes were submitted. To be presented at the March meeting.</p>	
10.54	<p>Terms of Reference</p> <p>For review by members and comments to: Patricia.Duncan@whht.nhs.uk</p>	
	Members were asked to review the new ToR for this group and comment to PD. She will then forward them to the Board for ratification.	
	AOB	
	None	

2011 Meeting Dates for CQuaC and IRaGC

Executive Meeting Room, Spice of Life Building, WGH

Date/Time	08:00	09:00
Thursday 10th March	CQuaC	IRaGC
Thursday 12th May	CQuaC	IRaGC
Thursday 14th July	CQuaC	IRaGC
Thursday 15th September	CQuaC	IRaGC
Thursday 10th November	CQuaC	IRaGC