

**CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

Minutes of the meeting of the **GOVERNOR/ DIRECTOR WORKING GROUP ON GOVERNANCE AND ASSURANCE** held on Tuesday 17 June 2008 in the Boardroom, Addenbrooke's Hospital.

**PRESENT:** Mr J O'Sullivan (Chairman)  
Dr A Alderton  
Dr K Castille  
Prof B Michell  
Mr J Potter  
Mr E Revell

**IN ATTENDANCE:** Mrs H McGhee

Apologies were received from Mr Burgin, Mrs Ewer, Mrs Goddard, Mr Greenhalgh, Mr Smith, Mrs Pharaoh.

**08/08 MINUTES OF THE MEETING 19 MARCH 2008**

Agreed

The minutes of the meeting held on 19 March were agreed.

**09/08 MATTERS ARISING FROM THE MINUTES**

There were no matters arising not covered elsewhere on the agenda.

**10/08 FUTURE REMIT OF THE GROUP**

Received. Paper on remit of the group

Jim O'Sullivan, Chairman, led discussion.

Noted

- (i) It was suggested that the meetings of this group and the other working groups could be re-structured round the yearly planning and reporting cycle to include items presently dealt with in separate seminars such as the annual plan. Other issues such as the timing of the meetings could also be considered.
- (ii) For this group, it was proposed that meetings could have an alternating focus between governance and assurance.
- (iii) A seminar style meeting was suggested, rather than a business meeting, to encourage open dialogue and discussion.
- (iv) The original intention of the establishment of the working groups was to ensure that directors could benefit from governors' input where this would be helpful.
- (v) The constitutional position of the working groups was queried as they were joint groups. It was proposed that they be reconstituted as sub-committees of the Board of Governors which directors were invited to attend. This would then allow more time for in-depth discussion of items which was not possible at the Board of Governors.
- (vi) If the groups became sub-committees members would need to be appointed to particular groups and expected to attend regularly.

- (vii) It would be helpful to the Board of Governors if items could be pre-discussed in these groups if constituted as sub-committees provided that information continued to be available to all governors.
- (viii) However a way would then need to be found to encourage informal contact between directors and governors, to fulfil the original purpose of the groups
- (ix) Any governor could request an issue to be raised at the main Board of Governors. Governors' views on various issues, such as the laundry issue, were very helpful to directors.
- (x) Chairs of the working groups would meet with chairs of Board of Directors committees in November, when ways of joint working could be discussed. An earlier meeting would be beneficial, and the Trust Secretary was asked to arrange this if possible.

Agreed

- (i) The Trust Secretary would discuss proposals with Dr Archer.  

Action: Ann Alderton
- (ii) The Trust Secretary to arrange an earlier meeting of chairs of working groups and chairs of Board of Directors' committees if possible.  

Action: Ann Alderton
- (iii) Chairman to report the discussion to the Board of Governors for consideration by the working groups on membership and PPI and forward planning.  

Action: Jim O'Sullivan

**11/08 SAFETY FIRST INITIATIVE**

Carol Heesom-Duff, Assistant Governance Manager, gave a presentation on the Safety First initiative.

Noted

- (i) There were both external and internal drivers for this initiative. External drivers came from the Healthcare Commission, NHSLA standards, and in particular, patient expectations. Safety was to be top of the Trust's agenda.
- (ii) Internal drivers were the need to move from a reactive to a proactive system; to provide assurance about the systems and to respond to recent serious incidents in the Trust.
- (iii) The programme was based around a regular clinical area safety assessment (CASA) complemented by a series of triggers. The Trust had initially used the Manchester Patient Safety Framework to establish the process, and it had been cascaded down from the Board of Directors through Senior Clinical Nurses to Ward Manager level, looking at the culture in each level of the organisation.
- (iv) The CASA used the information already available together with surveys and a half day assessment. They happened every six months. Between CASAs, there were a number of triggers to identify concerns, for example drug errors and mortality and morbidity rates.

- (v) The process had gone well in the two pilot areas (gynaecology and diabetes) The pilot results would be evaluated on 26 June. Roll out would take place in late 2008 or early 2009. The Patient Safety Executive which would oversee the programme and receive the reports had recently held its first meeting. However, there were resource implications if the programme was to be successful.
- (vi) The Executive was working on a patient safety strategy and wished to include patient safety in KSFs, and include patient safety 'walkabouts'.
- (vii) The intention was for safety to be embedded in the culture of the Trust, with triggers picked up monthly in each SDUs, and barriers in place to prevent error.
- (viii) Where problems became apparent, the team would monitor events and ensure that the causes were known and acted upon.
- (ix) The SDUs were identifying lessons to be learned from each other.

Agreed

- (i) Dr Jag Ahluwalia, Executive Medical Director, who chaired the Patient Safety Executive and Glenn Pascoe, Head of Governance, would be invited to attend the Group's meeting on 25 November to update the Group on progress.

Action: Mrs McGhee

- (ii) The Group thanked Carol for a very interesting and comprehensive presentation, and looked forward to hearing of further developments.

**12/08 BOARD ASSURANCE FRAMEWORK**

Received: Summary of Board Assurance Framework

Ann Alderton, Trust Secretary, reported.

Noted

- (i) The BAF was a living, changing document which identified the top risks to the organisation. The top twenty risks identified had been ranked at a recent meeting of the Finance and Performance Committee, and were reviewed by the Board of Directors at every meeting, whilst the complete Framework was reviewed every three months.
- (ii) A 'traffic light' scoring system was used to identify risks by scoring likelihood and consequence to arrive at a risk score of up to 20. Red risks were identified as those rated 16 or above.
- (iii) One risk which had been identified was that incorrect services were delivered in the community, shown by the fact that patients were coming to the Trust and by-passing GP practices. As a result of identifying the risk, the Trust was now getting monthly reports on demand management and was in dialogue with primary care providers. The Trust had to act on its assessment of its own risk. The issue would be discussed at the forthcoming Joint Board with the PCT on 2 July which would be the first since the PCT separated into provider and commissioning arms

- (iv) Governors suggested that Addenbrooke's could 'Kitemark' services provided in the community, giving recognition to excellent services.
- (v) Mr Potter explained that in his role as Audit Chairman, he needed to assure the Trust that the process for managing risks was adequate. The Framework informed the Statement of Internal Control, for which the Trust Secretary was responsible, which was the responsibility of the Chief Executive as Chief Accounting Officer of the Trust.
- (vi) The Framework was frequently reviewed and updated by the Executive.
- (vii) Governors could also contribute and use the BAF to inform their agenda, with regard to strategic risk.
- (viii) It would be useful to compare the BAF year on year to identify trends and establish if the Trust was reducing risk.
- (ix) There would be a risk to the Trust if there was a significant decrease in surplus as a financial risk rating of three would give the Trust less flexibility for developments.
- (x) The recent data loss incident was an ongoing issue.
- (xi) The complexity of rules and targets was a risk because of the lack of trained staff available to do business analysis.
- (xii) Risks from changing demographics had been dealt with to an extent with two new wards and two theatres being provided.
- (xiii) The differences between pandemics and major incidents were discussed.
- (xiv) There were risks when the Trust developed an innovative service which the PCT would not pay for, as had happened in the case of brachytherapy.

**Agreed**

- (i) The top twenty risks would be reported to the Board of Governors, and the Framework would be available to all those governors who requested it.

Action: Dr Alderton.
- (ii) This Group would be an appropriate forum to review the Framework on behalf of the Board of Governors, possibly at the March meeting each year, to provide input to the development of the Statement of Internal Control.
- (iii) Members thanked Ann Alderton for her helpful report.

**13/08 ITEMS FOR INFORMATION**

A meeting of the Governors' Constitution Committee was being arranged to consider the appointment of a Deputy Chairman, amongst other issues. It would be confirmed at that meeting that this Group would consider the Annual Report and Accounts at its next meeting, on behalf of the full Board, unless major issues emerged which warranted a full Board discussion.

Action: Dr Alderton

**14/08 DATE OF NEXT MEETING**

**Monday 8 September from 16.00 in the Boardroom.**

**This meeting will be attended by representatives of our auditors, KPMG (external auditors) and PWC (internal auditors), to discuss the annual accounts, key points raised in their management letter, and discuss key audit issues with governors**

**15/08 ANY OTHER BUSINESS**

Governors sought information on whether the problems relating to training of junior doctors was likely to recur this year. It was explained that the problem this year was more likely to be a shortage of doctors because of national work permit issues for doctors outside the EU. Dr Ahluwalia, Executive Medical Director, would keep Governors informed.