Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
24th June 2010

TITLE	**IGAC minutes- 21st May 2010**
SUMMARY	The IGAC had good attendance. Aileen McLeish Trust Chairman attended to observe.The Board is asked to note the following: The Risk registers have been discussed and key points noted in 5. The internal auditors have give 'significant control' assurance measure for their recent review of risk management with actions identified around improving training, and ensuring robust review of risk registers in ALL areas including non clinical areas (7) Actions have been initiated through CGC to assist with compliance for VTE risk assessment which is currently a high risk identified on corporate risk register(9.1) The Committee has requested a detailed progress report on NHS LA position; this is identified as a key external review that must be engaged with in order to support the Trust wide requirements to deliver a good assessment resulting in maintaining Level 2 compliance. This has implications for risk and safety, Trust reputation and financial costs (13.1) The new BAF was considered and changes recommended are noted in 6.1 Changes to the governance structure are noted 9.1.The TOR were reviewed. (Separate agenda item).
ASSURANCE (Risk) / IMPLICATIONS	The minutes provide assurance all aspects of the organisation's risks are being discussed.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	None identified
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	None identified
The Trust Board is asked to:	Note the minutes.
Submitted by:	Sarah Johnston, Head of Quality and Integrated Governance on behalf of Philip Beesley, NED and Chair
Date:	15th June 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)

Minutes of the meeting held on Friday 21st May 2010 1000-1200 – The Boardroom, St Peter's Hospital

Present:	Philip Beesley	**PB**	Non Executive Director (Chair)
	Andrew Liles	**AL**	Chief Executive
	Ben Endersby	**BE**	Internal Auditor (CVDFK)
	Caroline Becher	**CB**	Chief Nurse
	Jane Gear	**JG**	Head of Corporate Affairs
	Jill Down	**JD**	Head of Customer Affairs
	John Aird	**JA**	Interim Associate Director Health Informatics
	John Headley	**JH**	Director of Finance and Information
	Mark Kinsella	**MK**	Internal Auditor (CVDFK)
	Marty Williams	**MW**	Clinical Risk Manager
	Maurice Cohen	**MC**	Patient Panel Representative
	Paul Crawshaw	**PC**	Clinical Director Paediatrics (on behalf of Mike Baxter)
	Sarah Johnston	**SJ**	Head of Quality and Integrated Governance
	Terry Price	**TP**	Non Executive Director (Chair of Audit Committee)
Apologies:	Andrew Laurie	**ALa**	Consultant Haematologist / Associate Medical Director
	Mike Baxter	**MB**	Medical Director
	Raj Bhamber	**RB**	Director of Workforce & Organisational Development
	Paul Bentley	**PBe**	Director of Strategy
	Valerie Howell	**VH**	Chief Operating Officer
Minutes:	Pip Watson	**PW**	PA to Non Clinical Risk & Emergency Planning
In Attendance	Aileen McLeish	**AM**	Trust Chairman
Absent:	None		

The Chair welcomed Aileen McLeish who is attending a number of Committees to observe how they operate. PB welcomed any contribution from AM during the course of the meeting.

1 Apologies

These were noted.

2 Minutes of the Meeting held on 3rd February 2010

The following amendment was noted:
3.2 . CB updated the committee. The final piece of work relating to the patient property action plan is to implement the patient property record book. This has now gone to final print.

PB will make some minor adjustments to some of the content of the minutes which, once completed, will be sent to all members. **PB**

3 Matters Arising – Attachment 2

The Committee checked the action points to ensure completion, further action required or deferred to item on agenda.

3.1 Action Plan for Medical Device Management (3.3)
This item is covered under agenda item 4.

3.2 Scanning and Access of CAS cards in A&E (3.4)
JA assured the Committee that scanning of CAS cards is in place. There is an issue in that the workload is more that the administration capability can handle and this has caused a backlog. It was acknowledged that the Emergency Services and Information Department should be looking at how this can be resolved and AL stated that this must be done immediately and with no delay. PB requested an update report at the next meeting. **JA**

3.3 Management of Tolerated Risks (3.5)
Historically a summary of the tolerated risks is not presented to IGAC. Following the merger of the Non Clinical Risk Committee and the Clinical Risk Group it is envisaged that the new group would put together a tolerated risk report which would be reviewed bi-annually by IGAC.
PB felt that IGAC would require assurance that long term risks are regularly reviewed and followed up on.

3.4 Dummy JAG Visit (3.12)
There was no representation at the meeting for an update, however TP stated that at a previous meeting it was noted that the original JAG visit due in June has been postponed to December as the capital works around decontamination will not be completed until the end of June.
An update is required for the next meeting. **VH/MB**

3.5 NPSA Syringe Driver Notice (3.14)

There is still concern over the process in place within women's services in relation to use of syringe drivers for both epidurals and intravenous routes. Best practice indicates separate identifiable pumps should be used. Whilst the directorate believe they are adequately complaint with the safer practice notice by using the same syringe drivers but labelling them as for epidural use only and IV use only, medical equipment library staff have observed this practice not to be always implemented and there is a lack of knowledge amongst staff that this process is in place. This poses a risk to patients with potential serious consequences if drugs are mistakingly administered incorrectly. In addition there is a reduced level of service to patients requiring pain control when staff from other areas cover and are unfamiliar with the pumps in use. The cost of cost of consumables for the pumps is high and this is preventing women's services from moving to separate pumps.
A further interim solution has been agreed which involves delivering new

pumps to women's services via medical equipment library which will then provide visible different pumps however there is still disagreement between Women's services, and the other parties involved as to the level of risk that should be tolerated in this case and executive input is required to bring this to a conclusion. **CB/SJ** **SJ**
CB will discuss with relevant parties to agree level of risk to be tolerated Significant progress has been made but a further update will be required for the next meeting.

3.6 Appointments Commission Information (3.18)
Feedback to be brought to the next meeting. **TP/SJ**

3.7 Uninterrupted Power Supply Report (4.1)
Feedback to be given at the next meeting. **PB**

3.8 Move Risk from Admissions & Activity to Trauma and Orthopaedics (4.1)
MW assured that this was completed.

3.9 Identify Correct Placing of Risks (4.1)
This item is discussed under agenda item 7.

3.10 Change Name of Women's Services to Gynaecology on Risk Register (4.1)
This has been completed. PC questioned as to where Obstetrics now lay and MW confirmed they are still under Maternity Services.

3.11 Provide Extra Column on Risk Register Report to Identify Timing of Resolution (4.2)
MW confirmed that a new box has been included on the notification form requesting information on when they are expecting to resolve the risk and therefore this will be identified on the report for IGAC.
Matter complete.

3.12 Decontamination of TEMS Telescope (4.2)
SJ reported that the warranty is only valid if equipment is decontaminated by the manufacturer, therefore this kit must be sent back to Scotland for this process. Action complete.

3.13 Pharmacy Budget (4.2)
JH stated that the new pharmacy post is absorbed within current budget.

3.14 Paper Free System for Medical Results (4.2)
This would be a major piece of work. It is desirable to move towards a paper-free system but would need to be addresses as a wider IT project.
AL advised that this is part of the overall information strategy and therefore would not be part of IGAC's remit.

3.15 VTE Assessment Target (4.4)
It was confirmed that this has been placed on the risk register as a corporate risk. Action complete.

3.16 Clinical Guidelines on the Intranet (4.5)
This has not been discussed at TEC as yet.
PC to take this back to MB for further discussions with the CD's. **PC**

3.17 Accuracy of Reports (8.1)
This has been acknowledged and addressed.

3.18 Items 10.1, 10.3 and 10.4 will be covered under the SUI report – agenda item 11.

3.19 To Confirm Occurrence of Quarterly Review of Hygiene Code (11.1)
SJ will be covering this with Vanessa Avlonitis and the team that input into the hygiene code assurance and performance accelerator.
Action complete.

3.20 CQC Registration (12.1)
This will be covered under agenda item 12.

4 Medical Device Action Plan– Attachment 3

4.1 An updated version of the plan which had been generated by PBe was tabled. Neither PBe nor VH were present to discuss the report.
IGAC needs to be assured that there are robust processes to monitor and replace equipment particularly where a significant risk of failure has been identified. AL felt that implementation must be through the clinical directorates but that organisationally, there needs to be clarity on executive and senior management roles and responsibilities. There is a process and a budget for doing this. AL confirmed that VH will take on the Exec Director lead. The new Associate Director for Facilities and Estates, once appointed, should be responsible for appointing a person to this role. Once this person is in situ then both VH and the new Associate Director are charged with the plans for implementing and reporting processes through the clinical directorates. There will be some corporate decisions that will need a more strategic overview that would be taken through TEC. **VH**
CB concurred that there should be an Associate Director. The CQC would want to see the record of an Executive Lead as it also covers the decontamination of medical devices and once the whole structure is in place that there should be an asset register, proper maintenance and a replacement programme.

5 Risk Register Report – Attachments 4 – 4c

5.1 Attachment 4 – Risk Register Report
MW reported that there have been 42 new risks added to the risk register since February – of which 2 were corporate. The 42 risks were spread across the Trust directorates.
It was noted that there is some real progression of the register with the number of risk reviews increased and a significant number of risks decreased in risk level.
Training for grade 8 staff and above was provided – but there was a poor turnout. More feedback will be given under the risk register audit report.

5.2 Attachment 4a – Summary of Extreme and High Local Risks
It was agreed earlier in the meeting that a report on the tolerated risks from the new Patient Safety and Risk Committee would be presented to this group on a bi-annual basis.

5.3 Attachment 4b – New Risks since February IGAC Meeting
A progress column has been included as suggested at the previous meeting.

5.4 Attachment 4c – Summary and Progress of Corporate Risks
This is for information only.

5.5 CB questioned why there are asterisks against some of the risks on paper 4a. MW replied that this is due to progress reports requested but where no response had been received. This is a common issue in some areas even after repeated requests. Paul Saunders (Risk Register Administrator) will visit the staff responsible on an individual basis to provide additional support where required. MW will discuss the issue of non-responders with VH to resolve the problem. **MW**
The training that was arranged for Business Centre Managers and senior grades was not well attended. It is imperative that everyone who runs a service has an understanding of how the risk register works and how the Quality department can help engage them with the risk review process. More training sessions will be offered at the end of June/beginning of July. AL suggested that MW link in with VH to ensure there is full compliance by staff requiring this training. **MW**

5.6 MC stated that the Stephanie Marks building that opened the day before has no facilities for a collapsed diabetic patient to be brought down from upstairs. TP stated this was raised at the recent Clinical Governance Committee and assurance was given that measures are in place to mitigate this issue. It was agreed that during future building and refurbishment projects the risk team should be involved early in the planning stages to identify possible issues.
CB stated that the new integrated Patient Safety and Risk Committee would be monitoring any new works so that no development would go forward to the architects without input from Manual Handling, Health & Safety and the DIPC.

5.7 MC questioned the risk regarding junior doctors taking blood. It is felt that this is an issue that requires discussion outside the meeting to establish what the concerns are and what is being done to mitigate the risks. This information is to be reported to the next IGAC meeting.

5.8 MC requested that the lack of beds shown on the risk register be noted. PB stated that there is a lot of work going on around the management of the length of stay and management of the flow of patients. VH to update the committee at the next meeting. **VH**

5.9 The non uninterrupted power supply to maternity theatres – MW spoke with Eileen Nolan and there is an emergency supply via a back up generator now. There could be a longer term solution in terms of UPS incorporated with re-building works.

6 Board Assurance Framework (BAF) – Attachment 5 – 5a

6.1 JG tabled an updated version as there has been some considerable work taken place with Directors in refining the risks, assurances and controls.
The BAF has been aligned to the four strategic objectives as detailed in the Integrated Business Plan.
The Board has recently agreed an updated Corporate Business Plan for 2010 – 2011 and the intention is to review and refresh the BAF in light of this and to

improve the content to include the wider strategic risks.
Members reviewed the new BAF

Objective 1 – patient experience, outcome and safety
AL commented that the new government will be looking at outcomes and not processes.
Patient safety alerts will be part of one of the controls. AL questioned whether this was adequate to ensure safety alerts were completed in a timely manner – this was agreed that it would as controls are reviewed as to their adequacy.
AL requested that JG include timely responsiveness to changes. **JG**
TP felt that changes to car parking issues are also a risk to the patient experience and should be included. Members decided that the car parking issue is a local issue unlike the single sex accommodation which is a national issue.
Discussion took place around some of the wording – 'manipulation' in relation to data quality, reliability and robustness is not appropriate. Members questioned the level of data reliability, JA stated that that the Trust is reasonable on data quality but improvements could be made to the procedural management.

Objective 2 – workforce
AM felt that the Trust has now has a better reputation but there are departments that are lagging and these areas are struggling to recruit.

Objective 3 – clinical strategy
Some recommended changes:
FT status 'likely to be' and not 'means'
Future 'organisation' and not 'service'
Increase wording/finer definition to 'Loss of market share'
Trust 'develops' a poor reputation – not Trust 'has' ….
AL feels that the number one risk is not engaging with the GP's – as they have the budget.

Objective 4 – finance
AL questioned as to where the risk to the Trusts plan to reduce beds is in the process mapping phase.
Under Lack of IM&T strategy – JA felt there is a need to embed vision and passion and some drive to formulate a strategy to deliver services. JA to work with JG for wording to encapsulate this. **JA/JG**

It was suggested that the BAF should identify the inherent risk (initial risk rating with no controls in place) alongside the residual risk (risk rating once controls have been put in place and effectiveness is monitored). This would help the Board consider the effectiveness of controls more easily.
JG to consider this **JG**

7 Audit Committee Exception Report – Attachment 6 – 6b

7.1 TP reported on the following:

- At the last meeting the Draft Head of the Internal Audit Opinion 2009/2010 gave a very strong endorsement of the system of control which is a clear improvement from last year.
- Updates on the progress in implementing high and medium level recommendations from internal and external audit reports are reviewed quarterly. TP has held additional meetings outside the normal Audit

Committee meetings to address specific audit reports where a number of outstanding recommendations have been identified and is endeavouring to resolve these.

7.2 Review of Risk Register Audit Report (attachment 6a)

This comprehensive report was presented by BE of Chantrey Vellacott DFK.

The following was noted:

- The risk register is robust overall with good management in place
- There are areas of good practice with some areas for improvement identified
- The structure of the organisation is not aligned with the structure on the risk register in some areas and this has identified some areas that show no risks at all
- There is a need to be more rigorous in receiving risk updates in a more timely fashion
- Risk management training has been highlighted with details of attendance
- Risk is not an agenda item at certain team and clinical governance meetings – this must be addressed
- In the non clinical departments risk assessments were not being regularly completed and risk and the risk register were not being discussed

PB concluded that there were three key areas to address:

- Risk needs to be clearly mapped to the structure of the organisation
- Ensuring that all areas have a robust and thorough method for reviewing their risks on a regular basis
- Ensuring adequate attendance at risk management training

CB feels that there should be a sign up of a risk by the owner and an agreement of a regular review date depending on the seriousness of the risk. SJ suggested that for each directorate only the business centre manager may send in risks and therefore reviews will be required from them only as the responsible person.

AL stated IGAC had requested the audit due to the same discussion at each meeting: are these the risks, is there a concern, are they looked at and updated. The audit has identified that there are pockets of issues which are more about the people and not the process. AL is to brief VH on this and discuss the actions recommended to address the pockets where practice is not up to standard and ensure that this is top of the list of issues down the operational line. VH to report back to the next meeting. **AL** **VH**

CB is to action the areas noted on page 19 which fall under her remit regarding training attendance. **CB**

MW to pass a copy of the list of previously invited attendees to both CB and VH. **MW**

PB feels that there is an issue about reviewing – this needs to be specified with the profile raised when a risk is logged initially. **MW**

TP confirmed that this report has been presented to the Audit Committee and felt that due to the content it should be discussed at IGAC. TP assured IGAC that the Audit Committee will be following up on the recommendations as part of the overall tracking process.

AL suggested that there is another topic around clinical audit – whether the most important things are being audited and whether re-audits are being carried out. AL suggested that the internal auditors could link outside of IGAC to identify if there is a similar role in relation to clinical audit. This was agreed. **BE/MK**

7.3 Review of Mobile Data Security Audit Report (attachment 6b)
This review was carried out as part of the Internal Audit Plan for 2009/2010 and the purpose was to provide assurance that sound Mobile Data Security management arrangements are in place.
The level of work that was applied to control the environment overall following the SUI and the successful actions undertaken to rectify the problem were noted. In conclusion the report gave 'significant' controls assurance with two minor recommendations being pursued.
PC feels that Consultants feel disconnected from accessing information as a year ago they could access x-rays from their home, this needs marrying up with a remote access system. JA will investigate this and suggests that any consultant who has a problem to contact him. *Post meeting: JA forwarded to PW a copy of the Remote Access Service (RAS) instructions to be attached with these minutes.* **PW**

IGAC noted the positive remarks from the audit and also commended the team that implemented the actions following the action plan.

8 Finance Committee Feedback – Attachment 7

8.1 JH reported:
- The non-elective cap requires further work to understand what the drivers are and what the consequences could be.

9 Clinical Governance Committee Exception Report – Attachment 8

9.1 SJ reported:
- Compliance with VTE assessment is at 61% for Trauma and Orthopaedics and a new protocol has been introduced to improve compliance.
- Mick Imrie has been asked to identify a process whereby patients are not accepted for theatre unless they have had a risk assessment.
- Referrals from A&E to the anti-coagulation clinic have dropped – patients are being sent home without a test which highlights a risk of inadequate follow up treatment. Tanya Bernard, chair of VTE group, is working with the Chief Pharmacist to consider how to increase referrals. PB requested a report back at the next meeting to assure this is in place. **SJ**

9.2 PB highlighted the item of no dedicated social worker on site which, although it is out of the Trust's control and asked if there is any update on this.
CB stated that the head of Social Services is meeting with the Trust next week which will hopefully resolve the situation. PB requested that the Trust makes it clear that the problem does not lie with the Trust. CB agreed and remarked that there is an option to go back to the Safeguarding Children's Board for Surrey if there is no resolution of the problem.

9.3 SJ reported that three committees have now been dissolved, one of which has been replaced with a Patient Information Group. Dissolved groups are the Clinical Service Development Group and the Privacy and Dignity Group.

The work has been disseminated to other groups, namely the Clinical Audit and Effectiveness Group and the Patient Experience work stream.

10 Non Clinical Risk Management Committee Exception Report – Attachment 9

10.1 MW reported on the following:

Regarding the provision of storage facilities for A&E CAS cards – MW wished to highlight that at the Non Clinical Risk Committee the Deputy Chief Nurse had raised a concern that the CAS cards were being stored in a locked cupboard in the Post Graduation Centre which also stores equipment. This creates a risk of confidentiality even though the original risk has been avoided. JA stated that this has already been picked up and is being looked at by the Health Records Manager who has proposed some options. MW to discuss with the Health Records Manager. PB expected a resolution and confirmation of this at the next meeting. **MW**

10.2 MW advised that the final Non Clinical Risk Management Committee met yesterday. The annual report was received by all members. It is the intention to integrate this Committee with the Clinical Risk Group (who has its final meeting on the 2nd July) and be named the Patient Safety and Risk Committee which will be chaired by CB. Some background work has already taken place i.e. marrying the two terms of references and an example agenda from the Queen Vic hospital has been provided by BE.

11 Serious Untoward Incident Report (SUI) – Attachment 10

11.1 MRSA - root cause analyses has been carried out for the 2 recent MRSA cases. There has been an issue raised around the taking of blood cultures and some very stringent actions to ensure robust practise have been taken. The annual trajectory for the Trust is 5 hospital acquired MRSA infections, the Trust number now sits at 3.

11.2 Data breach - MW requested closure agreement from the committee on this SUI as the action plan has been completed – this was agreed.
AL requested JA to report to him directly that the two new actions have been taken. **JA**

11.3 The remainder of the attachment was presented by MW and discussed.

11.4 PB stated that as there are still some ongoing actions for which he requested MW will ensure completion and that the training issues are embedded and rolled out. MW confirmed this and stated that the directorates will be questioned through their presentations by the Clinical Governance Committee. **MW**

12 CQC Update – Attachment 11

12.1 SJ provided a brief update:

- Information is still being provided by the CQC to aid the Trust with tools and papers to support the new process.
- SJ stated that there is further clarity that the CQC will be looking at evidence of the 16 outcomes at both locations, rather than the regulated activity. A CQC assessor will be meeting with SJ, AL and CB and should provide more information in relation to this. Changes to the Performance

Accelerator tool and initial set up processes are required.

- Organisations will be inspected on an ad hoc basis from July 1st. These inspections will be carried out as a minimum, once every 2 years.
- SJ has 1 areas of concern –outcome 4 (care and welfare of users). Outcome 4 is a broad area and requires significant input from staff. SJ is working with Vanessa Avlonitis on this.

12.2 PB questioned if SJ is confident that the Trust will be ready for an inspection in July. SJ replied that although the timing is an issue she is confident that the wider work will be completed. CB stated that now is the time to take a more direct approach to owners for them to complete their evidence. PB and CB offered their support to SJ to get the message home.

13 External Reports and Inspections Report – Attachment 12

13.1 This report was discussed and the following noted:

- The Cancer Peer review has not been rag rated. Discussions have taken place with Lorraine Symes and there will be sub divided into a number of reviews to make the process more affective. This will be shown on the report at the next IGAC meeting.
- NHSLA has changed from green to amber due to some changes in the standards since the last inspection. MW stated that the evidence required for the inspection in January 2011 spans a full year from January 2010- January 2011. Work has already begun whereby requests have been made to HR and the Governance Managers for evidence in some of the areas which have proved problematic at the previous assessment, such as out of date policies.
- MW explained that 10% financial discounts for each level are given and the Trust is currently on level 2 where the Trust gets 20% discount on clinical negligence claims insurance. This could be lost if the Trust does not maintain its current level of compliance. PB requested PW to ensure this is a separate agenda item for the next meeting. **MW**
- CNST Maternity Level 3 changed from red to amber.
- Human Tissue Act has changed from amber to green following ALa taking on the responsibility of the Designated Individual. **PW**
- Healthcare Commission Safeguarding Children review changed to amber from green. Helen Sibley has requested this change to reflect the need for level 3 training. A roll out action plan is in place for this.
- JH stated that the amber rating for ALE should now be green. This was accepted by the members.

14 Terms of Reference Annual Review – Attachment 13

14.1 This was discussed and changes noted and agreed.
SJ to action this and forward the draft copy to PB to agree this prior to sending to the Board meeting. **SJ**

MW requested that the PICC report be part of IGAC's remit in light of the Board's requested changes in how this report is reviewed. This was agreed.

PB requested that the Duties and Responsibilities be included in the pack of papers for every meeting to remind all of these. **PW**

15 Any Other Business

15.1 BE tabled a draft copy of the Internal Audit Plan for 2010/2011 for information only

15.2 MW requested that the next meeting be changed due to the educational half day being on the same date. This was agreed.

16 **NEW date of next meeting**: Wednesday 11th August 2010 at 11.00am in the Boardroom, the Ramp, St Peters Hospital