Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
26th September 2013

TITLE	**Integrated Governance and Assurance Committee minutes**
EXECUTIVE SUMMARY	This report contains the minutes of the meeting held on the 16th July 2013.
BOARD ASSURANCE (RISK)/ IMPLICATIONS	IGAC now meets on a monthly basis and engages in full and frank discussions about issues critical to high quality and safe care. The recently developed QEWS dashboard will now follow a rigorous production, validation and publishing process. This tool acts as a tool for the committee to engage in 'horizon scanning' in a more evidence-based manner, thus ensuring interventions more effectively pre-empt any harms to patients and staff.
LINK TO STRATEGIC OBJECTIVE	The scope of the Committee includes assurance over all Strategic Objectives but the work of the Committee focuses on SO 1 and SO 4.
STAKEHOLDER/ PATIENT IMPACT AND VIEWS	This is the most senior Trust Board committee that focuses on quality governance and improvement.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	None identified.
The Trust Board is asked to:	Receive the minutes.
Submitted by:	Terry Price, Non-Executive Director and member of IGAC
Date:	19th September 2013
Decision:	For Receiving

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Chair of IGAC's report

Introduction

Enclosed are the minutes of the meeting that took place on 16th July 2013. There was no Integrated Governance and Assurance Committee (IGAC) meeting in August.

The meeting that was held on Monday 16th September was chaired by Mr Terry Price in Mr Philip Beesely's (chair) absence.

IGAC paid particular attention to three agenda items:
- The Royal College of Paediatrics and Children's Health Review.
- Responding to Francis and Patients First and Foremost
- The QEWS dashboard.

The Royal College of Paediatrics and Children's Health Review.

IGAC received a presentation from Dr Paul Crawshaw, Divisional Director for Women's Health and Paediatrics about the review, the action plan and assurance around the execution of the improvement plan. There was further discussion about how the learning will be shared.

Responding to Francis and Patients First and Foremost

The complete analysis of the Francis recommendations against the Patients First and Foremost domains was presented. The analysis focused on 63 themes and 149 recommendations from the Francis report. As a result of this, 451 actions were identified across three categories:
- Culture
- Process
- Combination of Culture and Process.

The key findings were that the Trust was more compliant with the recommendations than there were gaps, the Trust is strong on process and there is further development required to address 'cultural improvement', particularly around the patient and family experience during the end of life and bereavement.

The final report on the Trust's response to Francis will go to the November 2013 Board. There will be a review of the actions and gaps in 6 months' time and presented to IGAC in February 2014.

The QEWS dashboard

There was discussion about the dashboard and new indicator additions. Readmissions by wards were added and it was felt that this was not as meaningful a predictor of quality concerns. As a result, the QEWS dashboard will be further amended and will come to the Board in October.

Two wards in particular were discussed, Swan and Fielding wards, and the interventions that were taken to address growing quality concerns. Two more wards, Cedar and Wordsworth were also discussed at length as they were an emerging concern.

Ashford and St. Peter's Hospitals NHS
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INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC) MINUTES
Tuesday 16th July 2013
14:00 - 16.00hrs
Room 2 Chertsey House, St Peter's Hospital

MEMBERS PRESENT:

CHAIR:	Mr Philip Beesley (PB)	Non-Executive Director (Chair)
SECRETARY:	Mrs Heather Caudle (HC)	Associate Director of Quality (Secretary)
	Dr David Fluck (DF)	Medical Director
	Mr Simon Marshall (SM)	Director of Finance and Information
	Ms Louise McKenzie (LM)	Director of Workforce Transformation
	Mr George Roe (GR)	Head of Corporate Affairs
	Mr Terry Price (TP)	Non-Executive Director
APOLOGIES:	Ms Valerie Bartlett (VB)	Deputy Chief Executive
	Dr Michael Imrie (MI)	Deputy Medical Director
	Mr Andrew Liles (AL)	Chief Executive
	Mrs Suzanne Rankin (SR)	Chief Nurse
IN ATTENDANCE:	Mr George Absi (GA)	Head of Accreditation & Regulation (Minutes)
	Emma Lynagh	Management Accountant (Observer)

ITEM		Action
43 / 2013	**IGAC Forward Plan**	
	Noted.	
44 / 2013	**Minutes**	
	The minutes of the 13th June 2013 meeting were agreed as accurate and approved.	

45 / 2013 **Matters Arising**

The Committee reviewed all of the actions from the previous meeting.

DF

3/12.2. Serious Incidents in Gastroenterology.
The Medical Director to circulate to members of the Committee. To be signed off at the next Committee meeting.

6. MAU Data collection. **VB**
The Deputy Chief Executive to update at the next meeting.

32/2013. Incidents – SIRI Report including Pressure Ulcer Plan Review.
Completed.

33/2013. Action Trackers of all Quality and Safety Plans.
Completed.

23/2013, 7/2, 30/2013 and **31/2013** all on the agenda.

46 / 2013 **Board Assurance Framework (BAF)**

The Head of Corporate Affairs presented the BAF and explained that it was the first time the framework had been reviewed since April 2013. The Top Five Risks mirror the Extreme risks. The ratings of these risks had not changed.

It was pointed out that for Risk 2.5 all the actions put forward had been completed, however this was still listed as a risk in the document. The Director of Workforce Transformation to check and confirm. **LM**

For Risk 2.5, Director of Workforce Transformation to reference the work conducted by the NHS Leadership Academy and Hays Group and add work from the internal management programme. **LM**

Members agreed that the BAF was a positive tool for continuous quality improvement and providing assurance.

IGAC approved the BAF. To be presented to the Board.

47 / 2013 **Quality, Safety and Risk Management Strategy**

The Associate Director of Quality introduced the strategy progress report and gave an overview. The paper showed performance against the 8 deliverables, 12 tasks and 49 objectives showing steady progress and good work that has been undertaken within the Trust. No red ratings were recorded. 2.1.3, Delivering high performance teams to deliver high Quality and Safer care is amber. A consultation paper, to be published in August, proposes the devolvement of the quality team into Clinical Divisions, which will support the quality governance model.

The Chair asked what would facilitate the Trust's move from good to great. The Associate Director for Quality said that fully embedding quality governance, development and monitoring of Division's quality plans and a change in culture & behaviours of staff were some of the ways the transition could be made. The Associate Director of Quality reinforced that the Trust was going through a journey of continuous improvement.

The Medical Director stated that he had seen an improvement with the link between quality and performance processes.

The Chair summarised stating that progress had been made in:

- Strengthening the link between Committees and Division
- Improvement of the usage of QUASH days
- Use of data/information to drive change and improvement
- The cultural and behavioural change towards quality and safety.

IGAC noted the report.

48 / 2013 **Risk Register**

The Associate Director for Quality and Head of Corporate Affairs presented the paper. The paper outlined the following concerns:

- Corporate risk register is too long
- There is no link to the Quality, Risk and Safety Strategy
- Low risks were listed
- There was a variation in risk recording

The Associate Director of Quality summarised the approach taken in the review of the key findings.

HC

The Head of Corporate Affairs detailed each action point outlined in the document with the Committee approving the change of name of register and the proposed re-rating of the risks within the register. Board training would be arranged for the Trust to set out its approach to risk appetite.

Members stated that the risk register should include clinical risks as well as corporate risks.

HC, GR & MI

At a Divisional level, the management and usage of Divisional Risk Registers were generally not as strong as they should be. They were not being used generically as a tool for quality improvement. It was stated that ownership of the Divisional Risk Register needed to be at a higher level e.g. Associate Director of Operations. Therefore risk scrutiny could be at a higher level and their use for quality improvement be embedded at divisional level.

It was stated that within the Acute and Emergency Division, the Associate Director of Operations had devised a quality governance paper for their division, which included a monthly review of the Division's Risk Register on a monthly basis. The consensus was this should be shared with and rolled out to other clinical divisions.

HC, MI, GR

A discussion took place regarding where rare or unlikely / catastrophic effect risks would be recorded and monitored. The Committee agreed these risks should be outlined in the Trust's Major Incident Recovery Plan.

IGAC approved all the recommendations. To be presented to the Board.

49 / 2013 **Monitor Q1 Governance Submission**

The Head of Corporate Affairs presented. The A&E 4 hour waiting target was a concern and declared as a risk. A discussion took place regarding the paper. The Chair pointed out that the trends graph for the 4hour performance trajectory showed a 2 step change. The Medical Director questioned whether this could be linked to changes in coding. The target was being closely monitored by senior management.

The Chair stated that he agreed with the Amber/Red declaration.

The Associate Director of Quality informed the Committee that this data would be reviewed under tier 1 of the Care Quality Commission's new assessment system.

The document was approved. To be presented to the Board.

50 / 2013 **Quality Governance Review: Action Plan Progress**

The Head of Corporate Affairs presented the paper. Following a discussion with PricewaterhouseCoopers (PwC) and the Board an action plan was developed in December 2012 to address their recommendations.

As of the 8th July, all of the 16 actions within the action plan have been completed.

IGAC signed off as completed and approved the report.

51 / 2013 **QEWS Triangulated Dashboard**

The QEWS dashboard was presented and discussed in-detail.

Swan ward was scored as level 0 and had deteriorated from the previous two QEWs dashboards, where it was level 1.

Areas of concern were workforce (e.g. recruiting) and pressure ulcer data.

The Director of Finance and Information questioned whether a contingency plan could be implemented where a staff member could be relocated to the ward from another area. The Chair highlighted the importance of responding to this information on SWAN ward. It was decided that the Chief Nurse should be informed of this discussion and make a decision about moving a well-established into the team. . **SR**

The Director of Workforce Transformation stated that the "stability of workforce" data was the most useful Workforce data. The Director of Workforce Transformation to check Aspen Ward figures and review timing of this workforce data. She will also review the workforce indicators for future QEWS. **LM** **SR**

It was asked that the Chief Nurse reviews Swan and May Ward's data.

Falls were showing as a concern along with pressure ulcers.

The Medical Director requested data for re-admissions to be shown for each wards. This would create ownership and would stimulate discussion & provide valuable information for wards.
The Associate Director for Quality to take forward. **SM/HC**

IGAC noted the QEWS dashboard.

52 / 2013 **Action Trackers of all Quality and Safety Plans**

The paper showed the action log tracker which holds the actions considered necessary to ensure learning from all serious incidents/complaints. The percentage of conversation rates to blue status was discussed.

The Risk Scrutiny Committee to oversee the plan to ensure conversion. **HC**

IGAC noted the report.

53 / 2013 **Francis Enquiry Action Plan**

The Associate Director of Quality presented in the Chief Nurse's absence. The Chief Nurse to update the Committee at the September meeting.
The paper showed ASPH's position against Francis2 recommendations. This was presented as work in-progress and due to be completed by September 2013. A detailed gap analysis is located within the report showing whether each recommendation can be linked to process or cultural work streams.
It was stated that the paper could be difficult for the Board to interpret. A 2 page covering report was requested, which should highlight any major gaps and major priorities. The Associate Director of Quality to take forward.
At the September meeting, this agenda item will be discussed in detail.
The report was noted. **HC**

54 / 2013 **Care Quality Commission – Action Plan Update**

A verbal update was given. Each Ward now has a nominated "Documentation Champion" who acts as a specialist, point of contact and champion's best practice within the Ward. Documentation legal training is being given to Champions. Training dates are:

- Tuesday, 30th July 9.30am – 1.00pm, St Peter's Hospital Post Graduate Centre Room 1.
- Tuesday, 6th August 1.00pm-4.30pm, Ashford Hospital Education Centre Room 1.

Audit results within the "Compliance in Practice" audit, undertaken in June 2013 and the "Best Care" dashboards have demonstrated improvements in documentation. A CQC paper, including these audits, would be submitted to the Committee in September.

The Chair asked whether electronic records would help improve compliance and had this been discussed. The Director of Finance and Information stated that there were many E-Systems in use in the Trust e.g. Vital pack. A full appraisal of electronic records systems would need to be undertaken and discussed. **DF, SR, HC, SM**

I.T Clinical Leads input would be valuable. It was decided that the Medical Director, Chief Nurse, Associate Director of Quality and Director of Finance and Information would meet to discuss further.

The Director of Finance and Information and the Medical Director stated that the system needed to be user friendly and clinical buy-in was key to its success.

The item was noted.

55 / 2013 **Claims Annual Report**

The claims over the period were stable, with a £4 million insurance premium and a £2 million payout. Introduction of legislation of "No win, No fee" claims, allows the public to make a personal injury claim against the public sector, which may result in an increased amount of claims being received by the Trust. **HC** **SM**

The Director of Finance and Information stated that there was a large amount of claims still unsettled. With this in mind, future reports should be presented in the wider context.

A discussion took place regarding the NHSLA scheme, open competition and what were the options for the Trust moving forward. The item of Trust insurance was referred to the Finance Committee for further discussion.

IGAC noted the report.

56 / 2013 **Quality Governance Committee Exception Report**

The Committee discussed the Exception report.

Reference 5.2, The Surgery Division's declaration of red for Outcome 10 still stood however this equipment was on order. The compliance would be moved to green on arrive of the equipment. This will be reviewed on the 19/07. **HC**

Reference 7.1, a review of out-of-date/overdue for review Trust Policies on the intranet was being conducted by the Head of Accreditation & Regulation. A plan was in-place. An update will be given to the Quality Governance Committee in December 2013. **GA**

The Committee recommended that an Executive Lead was assigned to each policy and that the job title of the author was listed, rather than individual's name(s).

The report was noted.

57 /2013 **Patient Experience Feedback / Complaints Monitoring Group**

The Associate Director of Quality presented the paper.

It was questioned whether "communication" was a theme or trend. The Chair stated that using trend data would identify if improvements were being made and also stated that using words like "slight" improvement, should be used with caution. Both to be considered when producing the report for July's Board. **HC**

IGAC noted the report. To be presented to the Board.

58 / 2013 **Any Other Business**

1. An escalation to a major incident had occurred. The Medical Director went through the steps taken and stated that these were the correct steps.
2. Liverpool Care Pathway (LCP) is to be phased out within the year. Acute Oncology Service Lead is to meet with the Medical Director to construct a response. Lack of training and lack of compassion of implementation were highlighted as flaws in implementation of the LCP.
3. The Care Quality Commission (CQC) recently released consultation documents demonstrating their new model of assessment. A discussion took place regarding the proposed model and inspection criteria. It was agreed that the Trust would respond to the consultation paper. A paper to be presented regarding CQC compliance for the September meeting. **HC**

59 / 2013 **Date of Next Meeting:**

Monday 16th September 13.00 -15.00 Room 3 Chertsey House, St Peter's Hospital.