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

Trust Board
27th January 2011

TITLE	**IGAC minutes**
SUMMARY	The Board is asked to note the following: The Committee discussed the risk registers and the Board Assurance Framework and made recommendations. The NHS LA current status report and the risks to achieving compliance were noted and performance management actions put in place for the remaining compliance items. Exception reports from CGC, Safety and Risk, Audit and Finance Committees were received. The Committee requested a review on progress of the new CGC and the Safety and Risk Committee in April. TOR for CGC were agreed The Committee reviewed the Hygiene Code compliance report and the essential standards report and noted a concern that the essential standards assurance mechanism required consideration as to its effectiveness, and this is being taken forward by the Head of Quality and new Chief Nurse.
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 Chair
Date:	19th January 2011
Decision:	For Noting

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

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)

DRAFT Minutes of the meeting held on Wednesday 15th December 2010 1400-1600 – The Lecture Theatre, Ramp, St Peter's Hospital

Present:	Philip Beesley	**PB**	Non Executive Director (Chair of Audit Committee) (Acting Chair)
	Valerie Howell	**VH**	Chief Operating Officer
	Ben Endersby	**BE**	Internal Auditor (CVDFK)
	Sal Maughan	**SM**	Deputisation for Jill Down head of Customer Affairs
	Jane Gear	**JG**	Head of Corporate Affairs
	Marty Williams	**MW**	Clinical Risk Manager
	Maurice Cohen	**MC**	Patient Panel Representative
	Mike Baxter	**MB**	Medical Director
	Raj Bhamber	**RB**	Director of Workforce & Organisational Development
	Sarah Johnston	**SJ**	Head of Quality and Integrated Governance
	Susan Osborne	**SO**	Interim Chief Nurse
Apologies:	Terry Price	**PB**	Non Executive Director
	Mark Kinsella	**MK**	Internal Auditor (CVDFK)
	Donna Jarrett	**DJ**	Associate Director Health Informatics
	Andrew Liles	**AL**	Chief Executive
	Jill Down	**JD**	Head of Customer Affairs
	John Headley	**JH**	Director of Finance and Information
Minutes:	Sarah Johnston	**SJ**	Head of Quality and Integrated Governance

1 Apologies and Committee Duties and Responsibilities

These were noted.

3 Minutes of the Meeting held on 6th October 2010

The minutes were agreed as a true record with the suggested amendments completed.

4 Matters Arising – Action Points - Attachment 2

4 The completed action points were accepted

3.2 PB requested an update on CAS cards and to consider closure.
SJ fed back that the scanning of CAS cards is occurring and that HS (GM for paediatrics) is confident that safeguarding processes are robust and that staff can access data for readmissions. This is through the patient centre system rather than the scanning system. The wider access to CAS cards still requires some monitoring. VH stated that the backlog had been dealt with and a

system was now in place and that further monitoring should be taken forward by CGC and reported through exception report. This was agreed

4a PB requested item 4a to be closed and vigilance to be placed on ensuring robust where review of risks are requested, but updates are not completed in time for committee papers. The Committee therefore should concentrate on those risks where review dates are over three weeks beyond due date, or particular divisions that had clusters of out of date risks.

5 SO provided on consultation the nursing re-organisation.
The restructure will be better increasing the balance of experienced staff and will improve leadership capacity. Additional training is being provided to strengthen knowledge and skills of ward sisters which will mitigate any risks to decline in service during the next 6 months as the structure embeds. Due to improved skill mix we are expecting an improvement in patient care (partly due to reduction in temporary staffing). An enhanced pro active approach is anticipated in relation to risk management and improvements are anticipated in clinical indicators for example pressure areas and falls

6 Training to be provided for new chairs to groups to be established in Feb 2011 **SJ Feb 2011**

5 Risk Register Report

The risk register report and accompanying attachments were discussed.
MW noted good movement in the risk register with 18 new risks, 16 local and 2 corporate and 1 CRR going for consideration to TEC.
Summaries of the new risks have been added as requested at previous meeting.

Extreme Risk 319 relating to shortage of midwives was discussed. RB and SO reported that a number of midwives had recently been recruited and maternity now only have 5 vacancies which are being held for flexibility in the provision of workforce. Committee requested review of this risk takes place with Associate Director of Women's services, with recommendation that the risk level is reduced. **MW/(EN)**
Chairman noted congratulations to be passed onto EN for the success in recruitment.

CRR Risk 806 relating to policies was noted as being raised to 12 from 8 (remains high)
SJ reported that recent published CQC review relating to a trust recently inspected demonstrated very low tolerance to use of policies in draft resulting in non compliance with standards.
In addition policies required for NHS LA have been slow to arrive in the quality department with a number requiring further work to produce a final draft.
SJ reported that the aim would be to reduce risk in February once all NHS LA policies were in place, plus outstanding departmental policies which have been requested for completion by 30th December.
The committee noted that there was an expectation that the 50 NHS LA policies will be completed in time for NHS LA inspection, much work had gone into the nursing policies and that these were aiming for completion by 30th December. A list of policies and progress is requested for next meeting. **SJ**

PB requested a plan for future management of policies. **MW**

SO requested that dipped performance relating to VTE noted on Quality report is matched up with related risk and issues related to recording in IPL

VH reported that increased pressure through out the hospital meant that Risk 764 relating to delivery of targets had been increased and was likely to be high throughout winter period. Recovery plan to be established and to be sent to CGC members to provide risk scrutiny in January, and CGC and TEC in Feb

Risk 1089 MC noted the risk relating to lack of OP staff and raised concern that these issues should be addressed. VH reported that a number of solutions were being pursued and that this was not reflected in the risk. BE reported that the lack of staff had been raised as an issue in a recent audit report and review on this is required. **VH**

6 Board Assurance Framework

JG reported that the successful FT application meant that the two related risks would be removed. The Board will now be considering all the requirements for compliance and self certification, and there will be a risk(s) relating to this. A piece of mapping work will be done to ensure CRR, BAF and the risk log from the FT Project Board to capture this.

PB commented that the risks on the BAF remained relatively static in their assessment and invited the Committee to comment on this.
The Committee recognised that the BAF was dealing with significant and complex risks which were likely to be less dynamic than the corporate risks.

MC requested clarity on the adequate training issue for junior doctors. MB clarified that the risk to the Trust was around competency of junior doctors, whilst there was additional wider risk around training issues. MC suggested rewording 2.7 **JG**

PB invited comments relating to safety and patient experience. SO commented that the infection control risk would remain a high risk until April when new targets would be instigated. The group reviewed the assessment of the risk and noted that the risk should be registered as extreme in both the CRR and the BAF until the end of the current reporting year.
Risk around patient experience should start to reduce over the next year as work in progress is embedded.

VH reported a continued high level of emergency admissions also seen across Surrey and SE Coast.

VH reported on broader clinical strategy and ongoing work with GP's which offered the Trust both opportunities and threats and currently the risk remains high.

VH reported that the CIP's remained challenging, but achievable.

7 Clinical Governance Report

The exception report was received. MB reported on the first 'new style' CGC. Further work is required from the Divisions to embed the governance approach, including the Divisional dashboard which is currently work in progress. MB reported good cross learning discussion which was the aim of the change and positive feedback had been given from teams in relation to this. PB recommended a review of the Committee in six months time to consider how the new structure and remit is developing. **MB & Suzanne Rankin April 2010**

TOR were agreed were approved and ratified.

8 SUI report

The SUI report was received and discussed in detail.

Report number 5 MB reported that further input had been requested in one case to ensure professional responsibility was being addressed as well as considering process improvements. MW reported that previous issues around escalation of concerns had been identified in some incidents. MB confirmed that this is being discussed at the divisions Mortality and Morbidity meeting, and he is confident that learning is disseminated. MB and MW assured the group that the escalation issue is a particular focus for this incident review and a new process is being discussed which will be shared across the Trust in due course in relation to discussions relating to urgent or emergency care over the phone. VH suggested maternity SUI's for the last three years be reviewed to consider if any particular patterns could be identified resulting in action to reduce the risk. **MW/EN**

Report number 6. SO reported on learning from a maternity incident in which the patient had joint care between a private midwife and St. Peter's. Learning related to refining the process for emergency procedures but particularly to private midwife practises and recommended guidelines for joint care and patient choice.

Report number 7. MW requested closure on the lithotripsy incident. This was agreed in relation to the SUI process but MB noted that further report to Board was required and completion of actions will continue.

Report number 8 MB to check actions and report to Trust Board as previously agreed

Report number 9. MW requested closure on this SUI which related to a breech of the 26 week waiting time. An action plan is in place to ensure all appropriate resources are in place for the Trust to be able to take on this particular procedure. This has been discussed with the PCT who have agreed closure.

Report number 10. MW requested closure. This was agreed

Report number 11. MW requested closure. It was agreed that as an external report is required to ensure the Trust has dealt with any actions this SUI would not be closed until report received.

MB commented that an acute trust is a high risk business and the Committee should note that the SUI process operates in a robust way and SUI's are being reported appropriately. The Trust Board dashboard records all SUI numbers each month. PB also requested the Committee noted that the open manner in which patients were being dealt with and this excellent approach should continue. **MW/JG**

JG commented that the reporting for SUI's under FT status may not be as required previously. Process for reporting SUI's to Monitor needs to be clarified.

9 Care Quality Commission

Compliance with Hygiene Code

SJ reported that the 6 month review occurred with core team, process working well, DIPC is assured that compliance is good, all criteria deemed compliant and no risks identified

Essential Standards of Quality and Safety Report

SJ reported that following the Scarborough inspection review which has been recently published by the CQC, it has been possible to gauge the expectations of the CQC in achieving the essential standards. Standard owners had been asked to read the Scarborough review and consider a more risk averse approach in rating the standards to ensure that the information provided to IGAC is robust in relation to the likely outcomes of CQC inspection. The report therefore presents more amber ratings than the Q2 report as standard owners go through this process. An example of where improvement actions were issued by CQC, was where draft policies were in place rather than approved and active policies.

A further risk is the assurance that staff are visibly complying with the policies. Ideas for establishing improved assurance relating to this included enhanced local audit plans, (some areas are well established e.g. hand washing audit) safety walkabouts and peer review between directorates. It is anticipated that with the new divisional structure and Quality Department structure this is something that will be improved going forward. It is particularly important that we make the shift from process to outcomes.

SJ reported that not all the standards were being overseen in a consistent robust way and further work was required. The workforce standards are a good example of a robust process with over view being taken by the workforce strategy group and good management by standard owners and this approach needs to be embedded across all standards.
The performance accelerator should facilitate an efficient review process with executives being able to have overview of their standards quickly and effectively so allowing increased focus on improvements rather than monitoring. **SJ**
SJ recommended that a review of the current process with the new CN would be appropriate.
VH recommended clarity on the accountability of the standard owners and the performance approach and this to be fed into the standard owners and executives. MB commented that we need to be able to apply more rigour in the monitoring of standards.

10 NHS LA

MW presented the NHS LA action plan which is in preparation for inspection on 25th and 26th January 2011.
Main risk area is the work force standard as more than 3 criteria within the standard are weak. If more than 3 criteria fail within 1 standard the Trust will not achieve Level 2 NHS LA. This would have a significant financial impact.
MW reported agreement with RB to concentrate on areas that are more likely to demonstrate compliance. Work will be ongoing to ensure the best possible review and resources within the Quality Department are being focussed on this inspection.
IGAC requested that the action plan continues to be updated weekly and circulated to execs as well as leads and GM's **SJ/MW**

11 Safety and Risk Committee Exception report.

The Safety and Risk Committee Exception report was received and noted

12 External Reports and Inspections database

SJ reported that cancer peer review action plans are currently being reviewed

13 Audit Committee Exception Report

The Audit Committee Exception Report was received and noted

14 **Finance Committee Exception Report**

The Finance Committee Exception Report was received and noted

15 **Integrated Governance and Risk Management Strategy**

PB invited the group to comment on whether the Trust Board was receiving timely and accurate information that ensured issues were not hidden within too much information or text. Committee agreed the approach was good and continually improving, and that key items were being brought to the Board attention.

PB requested wording demonstrated a stronger emphasis on ensuring actions are taken forward and completed.

The integrated Governance and Risk Management Strategy was approved with some minor amendments and will go to Trust Board in December.

16 **TOR**

JG reported to the Committee that under the NHS Act any sub committee of the Board should be Executive membership only. The TOR will be amended to reflect this.

The quorum of the group is therefore amended to 6 members in attendance.

The TOR were approved

Any Other Business

PB reported that risk relating to the work being done out within the community including visiting nursing homes, outside clinics etc should be adequately captured and asked members for comments on this. VH reported that a robust process was in place for taking on external work and there were no current significant risks that had not been identified. The Committee agreed to consider this in more detail at the February meeting. **MW/PB**

BE informed the group that the SIC guidance had been issued to the Finance Committee and requested direction on circulation. Circulation to JG, SJ and VH **BE**

BE requested list of appropriate personnel to input into the 'clinical audit'.

PB thanked SO for her input into the group as this was her last meeting.

Date of Next Meeting

9th February 2011

2011 at 1400hrs – 1600hrs in the Boardroom, Ramp

Submitted by:	Sarah Johnston, Head of Quality on behalf of Philip Beesley, NED and Chair of IGAC
Date:	19th January 2011