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

**Trust Board**
**27th October 2011**

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| **TITLE** | **Integrated Governance and Assurance Committee Minutes** |
| **SUMMARY** | The Committee discussed the Corporate Risk Register, Board Assurance Framework and received exception reports from CGC, Safety and Risk, Audit and Finance Committees. In addition the meeting looked at<br><br>Meeting held on 6th September 2011 (DRAFT minutes attached)<br>▪ NHSLA Update following debrief<br>▪ CQC essential standards – assurance update<br>▪ IGAC Terms of reference<br>▪ Information Governance incidents |
| **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:** | Suzanne Rankin, Chief Nurse on behalf of Philip Beesley, NED Chair |
| **Date:** | 13th October 2011 |
| **Decision:** | For Noting |

**INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)**
**Minutes of the meeting held on**
**8 September 2011**
**1400-1600hrs – Board Room, St Peter's Hospital**

**Present:**

| | | |
|---|---|---|
| Valerie Bartlett | VB | Deputy Chief Executive |
| Mike Baxter | MB | Medical Director |
| Philip Beesley | PB | Non Executive Director (Chair) |
| Raj Bhamber | RB | Director of Workforce & Organisational Development |
| Claire Braithwaite | CB | Associate Director, Performance Improvement |
| Maurice Cohen | MC | Patient Panel Representative |
| Ben Endersby | BE | Internal Auditor (CVDFK) |
| John Headley | JH | Director of Finance and Information |
| Donna-Marie Jarrett | DMJ | Associate Director Health Informatics |
| Mark Kinsella | MK | Internal Auditor (CVDFK) |
| Andrew Liles | AL | Chief Executive |
| Terry Price | TP | Non Executive Director (Chair of Audit Committee) |
| Suzanne Rankin | SR | Chief Nurse |

**Apologies:**

| | | |
|---|---|---|
| Jill Down | JD | Acting Head of Quality |
| Jane Gear | JG | Head of Corporate Affairs |
| Marty Williams | MW | Head of Patient Safety |

**Minutes:** Anu Sehdev, Quality Team Administration Manager

**1 Apologies for Absence**
Jill Down, Marty Williams and Jane Gear

**2 Committee Duties and Responsibilities for Reference**
The document was noted.

**3 Minutes of the Meeting held on 8 June 2011**
The minutes were agreed as a true record except for item 4.3, second paragraph, where it should read "hand*ing* on major concerns".

**4 Matters Arising – Action Points**
The completed action points were accepted. It was noted that ongoing action points were on the agenda for discussion.

Item 7.2 Multi Disciplinary Team (MDT) Training
SR advised that the Royal College of Physicians had not yet made their MDT training package available. SR noted that St George's Hospital was currently testing the programme and that the package was free. In the interim, the new Head of Midwifery had been tasked with increasing MDT skills, looking closely at the nature of MDT training. An Obstetrician and Senior Nurse were to lead on this project using existing Educational Half Days to provide training.

SR to advise once the Royal College of Physicians' package was on line. SR

Item 4.5 List of Policies
SR advised that considerable progress had been made in tackling policies which were overdue for review. Going forward, SR agreed to provide 2 SR

weekly updates to the Executives on the status of policies. An escalation policy would also be considered.

**5 NHSLA**

5.1 Update Following Debrief in July

SR advised the debrief session was well attended and discussion had centred around the Trust's approach to attain Level 3, resulting in an action plan being produced to enable an assessment in Spring 2013 (attached to paper).

SR to invite a NHSLA assessor to attend for an informal visit in December 2011 to ensure the Trust's focus is in line with requirements. SR noted that the Epsom acquisition would need to be considered also.

RB advised that all staff had been sent a card with their payslips to enable the recording of training. Three surgery sessions had taken place to clarify what mandatory training was required in particular roles and a further project group would be in action later this month.

SR further advised that action plans were in place in nursing to tackle training requirements. SR agreed to update the group at the next meeting on the action plan. SR

**6 SUI Report**

Redacted due to patient confidentiality

**7 PICC Report**

The group discussed the report and it was agreed that the new Head of Quality would be tasked with reviewing the content and format and going forward include trends/themes, details on the monitoring of actions, audit details and mapping from risk register.

SR noted that reporting was stable, although drug errors had increased and this may be due to reporting of all issues. PALS conversion rate to Complaints was only 4% which highlighted the PALS service was effective.

The group discussed whether the report would be more suitable for presentation at the Safety and Risk Committee and Complaints Monitoring Group with exception reports to IGAC.

**8 Clinical Governance Committee Exception Report**

SR advised that there had been poor attendance at the last Clinical Governance Committee and that correspondence around the importance of attending had been sent to all attendees. AL commented that he noted papers were vast but there had been enough people round the table for a meaningful discussion.

Discussion took place around the slimming down of papers with divisional exception reporting only. The time spent producing reports was discussed and whether these could be standardised. DMJ agreed to attend the next meeting to provide progress on dashboards. DMJ

PB reminded the group that the whole committee structure was being looked at to ensure there was no unnecessary overlap in agendas. Report was due in December.

**9 Safety and Risk Committee Exception Report**

MB advised an IT code 5 tracker is planned to be piloted in the next couple of weeks in A&E, Respiratory Medicine, Rheumatology, Upper GI, Surgery, Vascular Surgery, Colorectal Surgery and Gastroenterology. This will then be rolled out to the rest of organisation. It is envisaged that this will be a better process for closing down code 5 reports and a formal escalation path will be introduced together with an audit trail in place. Once staff had been trained, pilot will be up and running.

MB confirmed that actions had been taken in all of the 32 reports outstanding and these were being monitored.

Discussion took place around the outstanding reports and who should be accountable. Although the Medical Director was advised of all code 5s and these were then disseminated to the divisions, it was felt that Divisional Directors should be more involved and included in the system. DMJ to incorporate into the system a report function which comes up when Divisional Directors log on highlighting status on code 5s. DMJ

12.1 PB confirmed that the mapping exercise on duplication in committees would be undertaken by SR and MB and the findings would be passed to IGAC as soon as they were available. IGAC would then take a view on the improvements recommended. SR to report back at the next meeting. SR

**10 Care Quality Commission (CQC)**

10.1 Essential Standards

SR advised that Nursing had developed a tool to help analyse the Trust's compliance to the safety and quality outcome measures. Details were handed out to the group. The group had gone on to analyse its own benchmarking scoring by deciding what was acceptable as a starting point for further analysis. Findings and action plans would follow. SR

SR advised that the CQC would conduct an unannounced visit to check the Trust's hygiene and nutritional standards. A second visit will follow requests for information and will check the Trust's compliance against all measures.

SR confirmed that 1,100 staff had undergone safeguarding training. It was hoped the new safeguarding nurse would be in post by January 2012.

SR advised there was a significant problem in the response rate for Complaints. This fell to 25% in August and was generally due to a huge backlog. Additional resource was now in place and the response rate had greatly improved. SR envisaged the situation would improve over the coming months.

10.2 Alert for Puerperal Sepsis

SR advised that the Trust was not an outlier for puerperal sepsis cases and the CQC has been asked to adjust the alert status.

**11 Risk Register Reports**

SR agreed to check information on the Risk Register was correct. SR

SR reported that initial work at reviewing risks on the Risk Register for over 12 months had enabled the closure of 7 risks.

Discussion took place around whether to start afresh with the Risk Register and whether consideration should be given to holding off until the Epsom acquisition. General consensus was that a new Risk Register should be developed as soon as possible, potentially by the Board during a session on risk management training.

RB agreed to follow up on the requirements for risk management training and contact the facilitator who had conducted previous training. RB

SR advised that Surgery had been requested to produce action plans to mitigate the risks against Never Events.

**12 Board Assurance Framework (BAF)**

Decision: The group agreed to delete risk 1.4 – Poor standards of information governance which then jeopardises patient confidence.

Potential risks surrounding the Epsom acquisition process were discussed and it was agreed that RB would speak with JG about detailing the risks. RB

MK confirmed that most trusts had a BAF and a separate Risk Register and agreed to forward a copy of a similar trust's BAF to the group. MK
The issue of taking a more radical approach to the BAF and limiting it more rigorously to the highest level risks was discussed. There will be further discussion of this at next IGAC.

**13 External Reports and Inspections Report**

VB advised there had been significant improvements in booking and wait times in Endoscopy, although more work was needed. VB agreed to report back at the next meeting on preparedness for the forthcoming JAG inspection in November. VB

**14 Audit Committee**

14.1 Exception Report
The Exception Report was received and noted.

14.2 Final Clinical Audit Report & 14.3 Clinical Audit Action Document
The report was received and noted.

TP expressed no concerns and advised the report was fair. An Action Plan (tabled) was in place to control detailing implementation dates and progress made.

14.4 External Assurance on Quality Report from KPMG
The report was received and noted.

TP advised there were a couple of issues identified.

14.5 Response to KPMG
Copy of SR's response to KPMG received and noted.

SR advised that the Trust had developed a Quality Account Dashboard.

MB informed the group that the Trust was looking into how the Trust reported surgery in hip fractures within 36 hours of admission and whether all missed fractures were captured. MB to report at the next IGAC. MB added he had no concerns as 100% patients had been put through the pathway successfully. MB

**15 Finance Committee Exception Report**

JH advised that the Trust's financial position had improved over the last few months in relation to activity levels and capacity issues. JH highlighted additional resources in place to address the gap in the CIPs' target for the year and that a steering group had been set up to review the various business models in the Epsom bid.

**16 IGAC Terms of Reference**

The group agreed the changes highlighted in red. Other changes were that Associate Director of Health Informatics should replace Head of Information and attendance would normally be required at 3 out of 4 meetings.

**17 Any Other Business**

Information Governance (IG)

DMJ welcomed the spotlight from IGAC which had enabled her to look at how IG incidents were assessed and produce an audit trail. The IG report was handed out and discussed.

DMJ hoped that the element of missing notes would be rectified when case-note tracking was introduced.

DMJ highlighted that the categories were set by the Department of Health and a fine of £500,000 could be imposed for IG incidents.

DMJ agreed to come back at the next IGAC with a more detailed report including a comparison with other trusts. DMJ

**Date of next meeting: Wed 7 December 2011 – Lecture Theatre 1330 – 1530hrs**

*NB: Change of start time*

**2012 Meeting Dates** all 2 – 4 pm in the Board Room

Wed 21 March 2012
Wed 20 June 2012
Wed 19 September 2012
Wed 12 December 2012

**Integrated Governance Assurance Committee**
**Thursday 8 September 2011**
**MEETING ACTION POINTS**

| Meeting Date | Item No. | Action | Lead | Timescale | Update |
|---|---|---|---|---|---|
| **8.9.11** | **7.2** | Advise when Royal College of Physicians' package of MDT training on line | **SR** | **ASAP** | |
| **"** | **4.5** | Provide 2 weekly updates on status of overdue policies | **SR** | **ASAP** | |
| **"** | **5.1** | Nursing mandatory training update | **SR** | **Dec meeting** | |
| **"** | **6** | Report detailing investigations in relation to SUI cases | **SR** | **Dec meeting** | |
| **"** | **8** | Attend next Clinical Governance Committee meeting to provide progress on dashboards | **DMJ** | **14 Sept 2011** | |
| **"** | **9** | Report function on IT code 5 tracker to be included | **DMJ** | **ASAP** | |
| **"** | **9** | 12.1 Findings of mapping exercise to assess duplication in committees | **SR** | **Dec meeting** | |
| **"** | **10** | Findings of action plans in relation to Essential Standards | **SR** | **ASAP** | |
| **"** | **11** | Check information on Risk Register correct | **SR** | **Dec meeting** | |
| **"** | **11** | Check requirements for risk management training and contact facilitator | **RB** | **Dec meeting** | |
| **"** | **12** | Speak to JG about detailing Epsom transaction risks | **RB** | **ASAP** | |
| **"** | **12** | Provide a copy of another trust's BAF to the group | **MK** | **Dec meeting** | |
| **"** | **13** | Check preparedness for forthcoming JAG inspection | **VB** | **ASAP** | |
| **"** | **14** | Check all hip fractures go to surgery within 36 hours and all missed fractures captured | **MB** | **Dec meeting** | |
| **"** | **17** | Detailed IG report including a comparison with other trusts | **DMJ** | **Dec meeting** | |