Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
30th September 2010

TITLE	**IGAC minutes**
SUMMARY	The IGAC had good attendance. The Board is asked to note the following: NHS LA current position was presented in preparation for inspection for Level 2 in January 2011. Assurance was given that the majority of criterion within the 5 standards was green; five risk areas were noted and discussed (4). Additional updates have been requested by IGAC on the run up to inspection, in addition to reporting to safety and Risk Committee. The Risk registers have been discussed and key points noted in 5. The PICC report was presented and discussed following its transfer from review at Trust Board to IGAC. This was well received.
ASSURANCE (Risk) / IMPLICATIONS	The minutes provide assurance all aspects of the organisations 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:	22nd September 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)

Draft Minutes of the meeting held on 3rd Aug 2010
11.00 – 13.00 The Boardroom, St Peter's Hospital

Present:

Philip Beesley	Non Executive Director (Chair)
Andrew Liles	Chief Executive
Ben Endersby	Internal Auditor, (CVDFK)
Jane Gear	Head of Corporate Affairs
Jill Down	Head of Customer Affairs
John Aird	Interim Assistant Director of Information
Mark Kinsella	Internal Auditor, CVDFK
Marty Williams	Clinical Risk Manager
Maurice Cohen	Patient Panel Representative
Mike Baxter	Medical Director
Sarah Johnston	Head of Quality and Integrated Governance
Valerie Howell	Chief Operating Officer

In attendance John Kelly — Non Executive Director

1 Apologies for Absence

John Headley Director of Finance and Information
Raj Bhamber Director of Workforce & Organisational Development
Terry Price Non Executive Director, Patient Safety

2 Minutes of the meeting held on 21st May 2010

Amendments were requested by MW - 13.1 delete 'such as Out of date policies'

The Minutes of the meeting held on 21st May 2010 were agreed as a correct record.

3 Matters Arising

The Committee reviewed action points to ensure completion, further action required or deferred to item on agenda. It was agreed that at future meetings completion of actions would be confirmed with SJ prior to the meeting and only actions not completed and due for report would be discussed. **SJ**

3.2, 10.1 JA provided a report on progress of scanning CAS card in A&E in order to ensure previous notes available to staff as required. Item closed. VH to check in with emergency services to ensure work continues. **VH**

3.4 VH reported that the 'dummy JAG visit' was not appropriate for assurance for the JAG assessment but reported that actions being taken forward were going well and no concerns. Item closed.

3.5 Concerns around the implementation of appropriate process for syringe drivers in maternity services have been resolved. Item closed.

3.7 VH assured the Committee that all areas, with reference to the uninterrupted power supply feeds, are maintained and reliable. Item closed.

3.16 MB assured the group that the CD's have been requested to review guidelines for their areas. Barry Sellick has been nominated as clinical lead for this piece of work. Item closed.

4.1 VH confirmed that she will be executive lead for medical equipment and work is ongoing to consider how the services relating to this would be best structured for the organisation.
Report back in December 2010. **VH**

5.5 & 7.2 Items relating to risk management audit taken forward. Training for senior staff well attended in August. Training ongoing in September. Item closed with report back on attendance as part of audit feedback in December. **MW**

5.7 MB assured the group of actions taken to reduce risk of MRSA, highlighting competency training and assessment, and phlebotomist only taking blood cultures. Item closed. The impact on MRSA infections will be kept under review.

5.8 VH updated the Committee of the difficulties surrounding bed capacity. PB requested that risks be identified on CRR as appropriate. VH reported that the Board is receiving reports on this issue also. Item closed.

7.3 JA assured the group that lack of access to RAS identified by a consultant was a one off issue and access was in place. Item closed.

9.1 SJ assured the group that referrals form A&E to anti-coagulation clinic had significantly increased and this would be continually monitored through pathology and emergency services at CGC. Item closed.

11.2 Date breech actions have been completed. Item closed.

11.4 SUI actions have been completed. Item closed.

13.1 13.1 – agenda item.

14.1 TOR changes made Item closed.

4 NHS LA Action Plan

MW presented a summary of current position for NHS LA risk management standards. The next inspection is due in January 2011, the Trust is aiming for Level 2, maintaining the level achieved in the previous inspection in January 2008.
Work commenced in January 2010 to ensure evidence for the whole of 2010 is available. MW presented the standards and criterion within each standard as a RAG rated table.
Key risk areas are:

- Induction documentation – this was a criterion failed previously.
- MDT – 4 training sessions have been set up
- Management of medical devices and equipment
- Transfer policy – previously failed, work is ongoing through LEAN

programme
- Harassment and Bullying – actions are in place to address this

NHS LA comprises of 5 standards. Within each standard there are 10 criterions. The trust must ensure that they pass 7 out of the 10 criterion to comply with the risk management standards.
AL stressed that for all risk management standards the aim should be to obtain a green rating.

5 Risk Register Report

5.1 MW presented the risk register report. A number of changes have been requested in relation to further improving the risk register in preparation for Monitor. These were discussed and agreed by IGAC. IGAC agreed that 1 CRR format will be used for TEC, IGAC and TB. This will be the format recently received by TEC. This has reduced the detailed history of actions and progress and the target risk level. Contacts should be lead managers. **MW**
It is noted that if history of actions and progress is reduced on the document this is not stored on the Datix system, therefore any requirement for archived information will have to be found through manual archives. There should be no loss of record of essential detail.

5.2 It was noted that the risk register continues to demonstrate a dynamic approach with changes in risks scoring evident in the report.

The Committee stated that there must be more challenge to directorates. In particular directorates should focus on their high risks and ensure risk scoring is reviewed, and that actions are being delivered in a timely manner.

Risks that are tolerated by the directorates should still be reviewed. Committee requested a risk report specifically for tolerated risks for October meeting. **MW**

5.3 Risk 957 was discussed – Committee requested MW to update for next IGAC. **MW**

6 Board Assurance Framework (BAF)

JG presented the BAF.

6.1 JG reported that infection control risks need to be aligned to the BAF. SO and MW to action this. **MW/SO**

6.2 The key control relating to hand held devices should be removed as these have not been taken forward.

7 Audit Committee Exception Report

Audit Committee report was deferred to the next meeting as TP not present

8 Finance Committee Exception Report

The Committee received an exception report from the Finance Committee PB asked the Committee whether the drive for reduction in agency costs was discussed in other forums, and whether reducing the agency cost was

realistic. AL reported that there were actions that could be taken to control agency spend more adequately and this was being put in place. This is an ongoing challenge but AL is confident that this can be improved without compromising quality.

9 Clinical Governance Committee Report

9.1 MB presented the CGC report for the meetings as follows:

- 20th May 2010: General Surgery, Medicine (ambulatory care), Pharmacy department

- 17th June 2010: Emergency services, and Control of infection Committee. CEAG, Resuscitation Group, Falls Group were due to present at the meeting, but presenters were not available on the day. This is an unusual occurrence. However action was taken by Caroline Becher (CB) Chief Nurse and relevant people contacted. CB requested email sent out to all participants at CGC to stress that attendance is essential and this has been done. The Committees have since presented or are rescheduled.

- 8th July 2010: Specialist Surgery, Medicine (Acute care), Imaging and endoscopy, Resuscitation group.

MB assured the Committee that actions were in place to address risks identified during the CGC meetings.

9.2 MB reported that a meeting is planned to review TOR and to consider a refocus for the Committee. The meeting will consider how the divisions will report, how key information is reported and improvements to process. Corporate issues will also be considered: this will include a focus on the audit function and corporate action plans which the Chair of CEAG will present, and consideration of essential standards of quality and safety where risks are identified.

9.3 SJ proposed that the Falls group report to the new safety and risk committee rather than CGC. This was agreed.

10 Non Clinical Risk Committee Report

10.1 MW presented the Non Clinical Risk Committee (NCRC) exception report.

10.2 MW reported that the report would be the last for this Committee. Safety and Risk Committee will take over this strand of the integrated governance and risk management structure commencing with the inaugural meeting in September.

10.3 The Annual report for NCRMC was presented.
SO expressed concern at membership and attendance demonstrated for some Committees and sought assurance that Chairs are aware of their responsibilities. This will be discussed at Safety and Risk committee.
IGAC requested that CGC provided assurance on attendance for Committees and Groups reporting to IGAC. **SJ**
The Committee requested that CGC provide an Annual Committee Report to IGAC.

11 Serious Untoward Incident Report

Marty Williams presented the SUI report.

11.1 Surgical error relating to lithotripsy was discussed.

11.2 The Committee noted that MRSA will not automatically be considered an SUI in the future.

11.3 The SUI relating to the intrauterine death was discussed. A full report has been given to the PCT. Action plan has been accepted and sent to SHA for formal closure. The PCT noted the good practice implemented around escalation procedure and this is being shared across the patch.

11.4 Wrong side surgery SUI. MW requested the SUI to be closed as all actions completed. Committee agreed. SUI closed

12 Care Quality Commission – Essential Standards Report

Sarah Johnston presented the Essential standards report.

12.1 SJ reported that whilst the reviews had been undertaken a number of standard owners had not completed evidence up load onto the Performance Accelerator database. The action plan is in place for the standards which details areas for improvement rather than any major risks identified.
The committee stated that evidence upload must be completed by Quarter 2 and a focus should be placed on this. **SJ**

12.2 A minor concern has been identified for outcome 6 co-operating with providers. VH has asked that this action plan be made more robust and reported back to VH. **SJ**

13 External Reviews and Inspections Report

13.1 SJ presented the external reviews and inspections report.
AL asked for assurance from VH that cancer peer review for breast care was progressing adequately. VH reported that actions were in place to move to one MDT.
No areas of concern noted.

14 PICC report (PALS, Incidents Claims and Complaints)

14.1 MW presented the PICC report. This report has previously been presented to the Board and will now be monitored through IGAC and will be received bi-annually.

MW reported that the data provided demonstrated that we are not low reporters overall, although the staff survey indicates that staff do not always report incidents that they see.

PB commented on the evidence of a culture of openness that was evident by the report and that this should be commended.

MW discussed drug errors and communication as key themes that occur through the report and are evident through all directorates.

The Committee requested the paper be provided with a summary of key themes, risks, and/or concerns in order to assist the Committee to focus on areas to be addressed for the next report. **MW**

15 Integrated Governance and Risk Management Strategy Review

SJ informed the Committee that the Integrated Governance and Risk Management strategy was due for renewal and presented a timetable for review which was agreed.

17 TOR

The TOR which were reviewed outside of the meeting were agreed by the Committee

17 Any Other Business

17.1 IGAC has been asked to provide a bi-annual report to the Board. The report was tabled and comments and input requested to be sent to SJ to be considered for the next report. **ALL**

17.2 BE informed the Committee that the Quality Account would form part of the Auditors Opinion report.

18 Date of Next Meeting

6th October 2010
1400-1600
Boardroom, the Ramp, St Peter's Hospital