Trust Board
31st March 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 action plan to ensure NHS LA level 2 was noted. Risks relating to NHS LA compliance were discussed and assurance requested for those criteria that failed inspection. The Committee discussed in detail progress towards ensuring all policies are up to date on available on the intranet Exception reports form CGC, Safety and Risk, Audit and Finance Committees were received and discussed.
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 Chair
Date:	18th March 2010
Decision:	For Noting

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

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)

Minutes of the meeting held on Wednesday 9th February 2011 1400-1600 – The Lecture Theatre, Ramp, St Peter's Hospital

Present:	Philip Beesley	**PB**	Non Executive Director (Chair)
	Terry Price	**PB**	Non Executive Director (Chair of Audit Committee)
	Andrew Liles	**AL**	Chief Executive
	Valerie Bartlett	**VB**	Deputy Chief Executive
	Mike Baxter	**MB**	Medical Director
	Suzanne Rankin	**SR**	Chief Nurse
	Harriet Stephens	**HS**	Deputisation for Raj Bhamber Director of Workforce & Organisational Development
	Maurice Cohen	**MC**	Patient Panel Representative
	Jane Gear	**JG**	Head of Corporate Affairs
	Sarah Johnston	**SJ**	Head of Quality and Integrated Governance
	Donna Marie Jarrett	**DMJ**	Associate Director Health Informatics
	Jill Down	**JD**	Head of Customer Affairs
	Ben Endersby	**BE**	Internal Auditor (CVDFK)
Apologies:	John Headley	**JH**	Director of Finance and Information
	Paul Doyle	**PD**	Deputisation for John Headley, Director of Finance and Information
	Raj Bhamber	**RB**	Director of Workforce & Organisational Development
	Marty Williams	**MW**	Clinical Risk Manager
Minutes:	Sarah Johnston	**SJ**	Head of Quality and Integrated Governance

1 Apologies and Committee Duties and Responsibilities

These were noted.

2 Minutes of the Meeting held on 15th December 2010

The minutes were agreed as a correct record.

3 Matters Arising – Action Points

The completed were accepted and ongoing actions noted for future review

4 Risk Register Report

4.1 The risk register report was presented by SJ.
PB questioned the number of low risks held by some corporate functions; this could be due to risks being captured by the divisions which is where the risk becomes apparent, or on the corporate risk register. Corporate functions should still monitor risk within their area and further assurance is required on this. SJ to review this and report back. **SJ/MW**
Ensure all heading names are aligned in reports. **MW**

4.2 Attachment 3a discussed. PB suggested that where high risks are identified review dates must be within 6 weeks to ensure progress is identified. SJ confirmed this is the case. On reviewing the list of high risks PB suggested this was not adequate information for assurance; MB assured the group that all the risks were discussed in detail at Clinical Governance Committee (CGC) and that adequate assurance should be given via the CGC report. This was agreed. In addition a recommendation was made that CGC could view the risk register as one item in a similar format to IGAC. **SJ**

Following discussion SJ reiterated that all risk owners were required to submit a review date and where the risk had not been reviewed this would show on the risk register as the due date having passed. Members were reminded however that papers were printed out 2 weeks prior to the meeting where possible so risks updated in that time would not show up on the report. SJ assured the Committee that only one risk was actually overdue on due date and that others had been reviewed but had not yet been incorporated into the report. **SJ**

Following discussion it was agreed that risk register reports remain in their current format.

MB suggested that the report could indicate whether the risk had been reviewed at CGC and SJ agreed to look into this.

4.3 **MW**

The new risks added since last meeting were discussed. MC commented that as no decision had been made to demolish the old chimney this risk should be listed as tolerated.

PB stated that 'non compliant equipment' risk needed to have more
4.4 information.

Att 3c – SJ reported that the risk relating to Outpatients what-needs more definition-had been reviewed as requested and the rating reduced to medium. However this did not show on this months attachment as this was a recent review post papers being issued.

Risk 1072 – PB commented that a request had been made by the Trust
4.5 Board for a report on discharge issues and this would be reviewed at the Trust Board in March.

SJ presented a detailed report on the action plan for the risk relating to policies.
SJ reported that a decision had been made at Corporate Co-ordinating Group that policies would be managed via the departmental leads and heads of service rather than the policy owners.
This should improve management accountability.

SJ presented the list of policies that were still overdue. Medicines policies and nursing policies are the two areas that still require action plans to ensure delivery as these areas have larger numbers still to review.
All other areas are almost complete. AL requested that dates for completion were required for each policy. **SJ**
AL requested that SJ send to AL a list of policies, name of person and date for completion. SJ also to look at list of policies that will come up for review in next 6 months to ensure staff know that these are due.

5 Board Assurance Framework

5.1 The Committee reviewed the BAF. AL requested the group to consider that the BAF has a dual role now that the Trust is a Foundation Trust. The BAF still provides assurance of controls against the corporate objectives, but also now needs to provide assurance for the Board that the Trust is managing the risks around self assessment for authorisation.

5.2 JG stated that the risk log from the Foundation Trust Project Board had been mapped across to the BAF and the Corporate Risk Register and JG requested that the risk log now be discontinued. This was approved by IGAC.

5.3 JG suggested that the BAF would also identify where risks relate to authorisation, in order to demonstrate that we have managed these risks during the year

5.4 **JG**
JG informed the group that the risk relating to renal services should be removed as tendering process had now closed. This was approved.

5.5 **JG**
MC commented for the group that the PPEG had been dissolved and this needs to be removed form references

5.6 The group discussed the infection control risk currently rated as extreme; **MW**
this risk rating had been related to the risk of not achieving Foundation Trust status and therefore this was no longer an extreme risk in view of the improvement in relation to MRSA. IGAC agreed to maintain the risk
5.7 but reduce to medium.

PB asked VB to comment on the management of the non elective cap. VB commented that the overall emergency admissions have been increasing over several months and schemes put in pace to address this are starting to demonstrate improvement though not yet large scale.
The Committee therefore noted that the risk remained extreme. Ongoing actions were in place to mitigate the risk and this would need to be
5.8 monitored closely

PB commented that the non compliance with climate change was a difficult issue and challenged the rating as the targets were difficult to **VB**
achieve over the relevant period of time. BE informed the group that a piece of work was ongoing and guidance and timelines had been recently adjusted and therefore this was appropriately rated low at this time. TP commented that although this is currently a low risk it will increase in the future as we get nearer to target dates. AL questioned whether the Trust is doing enough to mitigate this risk.
5.9 The risk needs to be discussed in more detail at next IGAC taking **MB**

information currently being provided to Audit Committee into account.

5.10 The group discussed the risk to our strategic objectives relating to the rationalisation of services particularly for vascular and cardiology work. MB to consider adding this risk.

JG informed the group that there were changes to these risk ratings in the BAF, where previously the group had commented that ratings appeared static. The group noted that the risks had been raised and acknowledged this was appropriate due to the increased demand over the previous months.

AL asked VB to assure IGAC that where risks had increased the effort to address actions had also increased. VH informed the group that operational focus was more robust, winter pressure money was being spent in addressing relevant risks, interagency working and north west

5.11 surrey project work was in place, performance management has stronger focus and these efforts demonstrated further efforts to manage the higher rated risks. **JG**

5.12 **JG**

IGAC agreed that the the amended version of the BAF was fit for purpose as our post authorisation BAF.

6 SUI report

The SUI report was received and discussed in detail.

6.1 SJ reported there were no SUI's to close this month

6.2 SJ reported there were a number of SUI's awaiting closure by PCT

6.3 MB requested that 'delayed diagnosis be changed to 'missed diagnosis for number 5 in report **MW**

6.4 MB requested clarity on the SUI 2 relating to the 3 cases of Cdiff and whether this should be reported or not. This has been reviewed and this SUI has been reported as initially directed and therefore the process for review will proceed

6.5

MB reported that there was an action plan to address the recurrent theme of missed diagnosis that is evident in 3 SUI's currently open. MB reported that the 3 immediate actions identified in the SUI report were in place and being reviewed.
DMJ reported that an IT approach is being developed. This will not be able to be immediately resolved but a solution should be available within 2-3 months.

6.6

PB requested that the Committee consider whether there was sufficient assurance that the risk of a patient having a delayed or missed diagnosis was sufficiently reduced. It was agreed that robust assurance was in place via the action plan but that further review was required to ensure all actions were being carried out. **MW/MB**
A further report is required at next IGAC with the updated action plan

6.7

AL noted that a number of actions relating to housing and borough **MW/MB**

councils and their impact on discharge processes were not captured on the action plan and this needs to be more joined up.

6.8 The group discussed the action plans around the SUI's in general and the effectiveness of the approach. The group discussed possible improvements in delivery of actions through providing shorter outcome focussed actions, with clear indication of whether actions were for local areas, or wider Trust actions, and also actions that interlink with other work such as the discharge group. **SJ/MW**
PB noted that all action plans should be in the same format.
SJ to review with MW and SR and to be demonstrated in further action plans.

7 Care Quality Commission

SJ presented the CQC report.

7.1 SJ reported that there is no Quality and Risk Profile (QRP) for January therefore the most recent QRP information is from December 2010.
SJ reported no red ratings in the QRP and no decreasing ratings for December 2010.

7.2 SJ reported ratings of amber and green for the essential standards as assessed by the outcome owners.
SJ informed the Committee that the process for monitoring essential standards and use of performance accelerator needs to be improved. This includes linking of evidence, provision of status updates and monitoring by executive sponsors.
SJ reported that a review of owner responsibilities had been undertaken and all outcomes were now owned by the senior manager reporting directly to the executive sponsor. Training is being provided to support management of the system.
SJ requested that executive sponsors ensure the quarterly status summary is reviewed with the outcome owner to ensure agreement on current position is discussed and actions acknowledged.

7.3 IGAC agreed that the accountable person is the relevant Executive. Execs are to agree with the relevant owners how this is to work between them with support form SJ. **Execs/SJ**

7.4 JD enquired about how the CQC would inspect or request information

from the Trust. SJ reported that this could be either desk top review or inspection. All Trusts will be inspected once in a two year period therefore the Trust will receive an inspection in 2011/2012, and targeted inspections will occur if a risk is identified by the CQC.

7.5 SR stated that the QRP should be the signpost for where we are dipping in performance, as this will be the tool that CQC use. SR also reported that a team of specialist nurses have been requested to set up a peer review with the sixteen essential standards as the framework.
AL requested that that review be fed into the Board and members of the Board should be involved in this.

7.6 JG asked whether the mapping of standards to committees is robust; SJ reported the standards were mapped and documented in Terms of Reference. However some committees were more robust in the reviews than others andis needs further review.

8 NHS LA

8.1 SJ reported that the Trust had had the Level 2 NHS LA inspection on 25th and 26th January and had passed 43 out of the 50 criterion.
The inspector had informed the Trust that further work was required in relation to our mandatory training policies and process and a period of improvement has been given to allow the trust to complete that work.

8.2 The Committee discussed the risk that a poor process for mandatory training represents, and in particular how we close the loop in relation to providing assurance that all staff have attended training.
SJ presented the action plan for improvement which had been discussed and agreed with RB and SR.
AL reported that the inspectors had described care on the ward as good and policies and processes as requiring more improvement.

8.3 Action plan is required to ensure that policies are more robust and how we go forward. **MW**
TP requested assurance on the other criteria that failed the inspection.
SR reported that these areas were being reviewed and the Committee agreed that these areas need to be identified on the risk register .

8.4 PB asked that as the Trust was not rated 100% for mandatory training should this be on the Trust scorecard as this was not a high enough profile at the Trust Board.
AL stated that this will be a focused action in the business plan for the divisions to ensure action is taken where staff do not attend.

8.5 Update on improvement action plan required for next IGAC
Information on other criteria that failed to pass inspection – are there any material risk that are apparent **MW**
Action plan for going forward required for June IGAC including Level 3

9 Safety and Risk Committee Exception report.

The Safety and Risk Committee Exception report was received and noted.

9.1 SJ reported that the Information Governance training was currently at

23% and 100% was required by March 2011. DMJ reported that DH had now extended the deadline for this training to end of June 2011, and a focussed approach is being maintained to ensure the training is completed. DMJ reported that for more junior staff, and those that do not have English as the first language, the completion of the training is requiring more input and support.

DMJ confirmed that this training is mandatory and required for the Trust Terms of Authorisation and anticipated that the training standard would be achieved with current measures in place. However executive support to raise profile on this would provide support to achieve this target. **Execs**

10 External Reports and Inspections database

SJ presented the external inspections and reviews database.

10.1 VB reported that the JAG inspection had been delayed; areas have been refurbished and actions have been completed. Delay has been instigated to enable the new divisional structures to be embedded to ensure a good result.

11 Audit Committee Exception Report

The Audit Committee Exception Report was received and noted

12 Finance Committee Exception Report

The Finance Committee Exception Report was received and noted.

14.1 VB reported on increased agency spend; there is a significant recruitment problem in A&E with consultant and middle grade vacancies being difficult to fill which is a national problem In addition the winter pressures have meant additional resource needed over this period. VB and RB are working to address this and reporting on progress to Finance Committee.

13 Integrated Governance and Risk Management Strategy

13.1 The Committee was asked to note the amendments made to the Strategy where Chairman's action had been taken. This was noted and approved.

13.2 TP advised that the annual review should allow the document to be reviewed by Audit committee, approved by IGAC, and ratified by Trust Board in that order. TP recommended September for review and SJ will consider this **SJ**

14 Any Other Business

No other business

Date of Next Meeting

6th April 2011
1400hrs – 1600hrs in the Boardroom, Ramp

Submitted by: Sarah Johnston, Head of Quality on behalf of Philip Beesley, NED and Chair of IGAC

Date: 18th March 2011