South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	31 May 2012

This paper is for: (Only 1 column to be marked with x as appropriate)	Action/Decision	Assurance x	Information

Title:	2011/12 End of year report on the work of the Integrated Governance Committee

Purpose:	To provide assurance that the committee has discharged its duties and delivered its annual business plan in 2011/12.

Summary:	The report demonstrates that the Committee has met its terms of reference in 2011/12. Actions carried forward into 2011/12 include: ▪ Agreeing the work required to provide assurance in relation to Governance between Organisations. ▪ Establishing a process to receive assurances that quality is maintained as services are redesigned and productivity and efficiency projects are implemented. ▪ Receive assurance on progress towards implementing a new revalidation process

Prepared By:	Ruth James Deputy Director of Healthcare Governance and Quality	**Presented By:**	Ruth James Deputy Director of Healthcare Governance and Quality

Recommendation:	The Board of Directors is asked to support the findings of the report.

Implications (mark with x in appropriate column(s)	Legal	Financial	Clinical x	Strategic	Risk & Assurance x

Annual report on the delivery of the Integrated Governance Committee 2011/12 Annual Business Plan.

1. Introduction

The purpose of the Integrated Governance Committee (IGC) is:

> "To assist the Board and organisation in ensuring it fully discharges its duties in relation to clinical and corporate governance.
>
> In the progress of its work, the Committee will draw to the Board's attention any areas of concern that places the Trust at risk of non-compliance or threatens delivery of its strategic objectives.
>
> In achieving these ends the Committee will provide assurance to the Board that there are appropriate systems, processes and behaviours within the Trust which support the achievement of the Trust's strategic objectives and compliance with regulatory obligations."

To support the committee in discharging these duties an annual business plan sets out the actions required to meet each of the terms of reference. The business plan showing the status of the planned actions at year end is attached for information in appendix 1. There is one outstanding action (in yellow); all other planned actions are completed.

2. Review of Terms of Reference (ToR), attendance and membership

The 2010/11 annual report of the work of the Integrated Governance Committee was presented in May 2011 and it was concluded that the group had fulfilled its terms of reference in the previous year.

The ToR for the committee and annual business plan were reviewed at the meeting in May 2011. The group also approved changes to the membership to reflect the integration of community services.

Attendance at IGC over the year is attached at appendix 2. Average attendance was 63% which is an improvement on the previous year (when it was 55%) and all but 3 of the members have exceeded the 50% minimum attendance specified in the terms of reference.

3. Duties of the Committee

3.1 Governance Reporting

The Committee considered the Quarterly Trust-Wide Governance and Quality Report in May, September, November 2011 and in February 2012 and agreed the issues for onward reporting to the Board and those where further analysis was required. In May the Committee commissioned a review of Trauma's quality indicators, for next quarterly governance report and a report to Board on Trauma's overall performance in light of their reconfiguration and financial position. In September it

was agreed that the governance report should routinely go to the Council of Governors and further work was requested to look at complaints relating to all aspects of clinical care and also complaints about long waits for treatment, this was followed up in the meeting in December 2011

The Committee also considered other reports as identified in the annual business plan including:

- The CHKS Signpost report was presented in June 2011, there were no significant issues of concern and it was agreed that in future these reports will be presented to Clinical Standards Sub Group and only to IGC by exception.
- In relation to Information Governance (IG) the committee received a number of reports during the year, the IG annual report was received in July 2011, and update reports on the trust's compliance with the IG toolkit were presented in November 2011 and March 2012. The IG team also produced a report to provide assurance of the organisation's compliance with the Guidance for NHS Boards: Information Governance published in August 2011.
- An update on compliance with the NHS Constitution was reported to the Committee in November 2012.
- The Committee supported the 2010/11 draft Quality Account in May 2011 prior to its approval by the Board and publication with the annual report. It received a mid-year progress report on the delivery of the quality priorities identified in the 2010/11 Quality Account, and considered a progress report on the production of the 2011/12 report in March 2012. In addition a separate report was presented to update the group on the work taking place in the trust to improve the management of the discharge process which was one of the 2010/11 quality account priorities.
- An exception report on the risk to achieving the 62 day cancer target was reported in April 2011 and followed up in May with a further update confirming that the target had been achieved and plans put in place to support delivery of the required standard going forward.
- The committee received a gap analysis on the Trust's compliance with Monitor's Quality Governance Framework in April 2011 and supported a declaration of compliance with the Framework throughout the year. One area of on-going work in respect of the Governance Framework is the need to ensure that there is a process to ensure that any service redesign work of productivity and efficiency projects do not adversely impact on quality of services to patients.

3.2 Care Quality Commission (CQC)

The Committee has a duty to seek assurance of compliance with regulatory requirements and has received the following reports in relation to the registration requirements of the Care Quality Commission:

- The CQC quality and risk report was reported to the Committee in June and November.
- The outcome of the CQC inspection of the JCUH site which took place on the 6th of January was reported in February 2012. The report showed full compliance with the essential standards of quality and safety.
- A verbal briefing was given in March 2012 to the Committee on the site visit of the Mental Health Act Commissioner to inspect the notes of patients detained under the Mental Health Act.

3.3 Quality of Care and Patient Safety

A range of issues are considered in this section of the agenda to ensure that the Committee discharges its duty to assure itself that:

> 'The Trust delivers high quality patient centred care, particularly with regard to patient safety, clinical effectiveness and patient experience.'

- The clinical audit annual report for 2010/11 was presented in May 2011, all of the planned audits had been completed with the exceptions of the discharge, medical outliers and DNAR audits, the reasons for the delay in undertaking these audits were accepted by the Committee and these requirements were incorporated into the 2011/12 annual plan
- The annual clinical audit plan for 2011/12 was approved in July 2011, the plan demonstrated how the trust wide priority audits linked to the delivery of the Trust's annual objectives. A mid-year progress report in December 2011 showed that the plan was on-track.
- Following an apparent increase in fractures resulting from a fall a detailed analysis of these incidents and the underlying root cause analysis was presented in July 2011 and it was agreed that a further update was required at the end of quarter 2, this was subsequently presented to the Committee in November 2011.
- With regard to patient experience the committee received an update on progress with the patient experience strategy in June 2011, a report of the quarterly same sex accommodation and in-patients surveys in October 2011 and an update on the provision of breast feeding facilities in the Trust in June 2011.
- Complaints are reported to the committee as part of the quarterly trust-wide governance and quality report. In addition the Committee received the annual complaints report for 2010/11 in June where it was agreed that further information was required on the process for learning from complaints. Later in the year the Patient Relations manager presented a report on the monitoring of complaints action plans; compliance with the submission of action plans showed room for improvement and the Committee supported an escalation process to address this. The national report produced by the Parliamentary and Health Services Ombudsman was presented to the Committee in May 2011. Finally, in March 12, the Committee considered a report on the outcome of a trial period of changes to the complaints process, which identified some areas which were working well and some areas for improvement.
- The annual claims report was presented to the Committee in September 2011, it was agreed that this report should be escalated to the Board.

The Committee reviewed the following strategies:

- The Risk Management Strategy and KPIs in July 2011.
- The Patient Safety Strategy and KPIs in July 2012, together with the terms of reference for the Patient Safety Programme Board.
- Progress with the Patient Experience Strategy.
- Update on progress with the Learning Strategy

Other items reviewed in this category include:

- An update on the care of the deteriorating patient

- Briefings on the integration of the community service division into the governance structure in March and April 2011.
- Update on hand hygiene monitoring in April 2011.
- Compliance with NICE guidance reports – September 2011 and March 2012.
- The annual SUI report - September 2011

3.4 Risk and Assurance

There are two specific duties of the Committee covered in this section of the agenda:

> 'Appropriate systems of risk management and internal control are in place. '
>
> 'Action plans, risk alerts, and lessons learned are disseminated and implemented throughout the Trust, and actively monitored.'

The following agenda items considered by the committee in relation to this part of its remit are as follows:

- The Board assurance framework and corporate risk register were reviewed at every meeting during 2011/12. During the year the Committee escalated two risks for consideration by the Board; the risk to the achievement of level 2 compliance with the NHSLA risk management standards and the risk associated with staffing levels to cover the urgent care centres in the community hospitals.
- The Statement of Internal Control for 2010/11 was reviewed by the Committee in May and a mid-year update was presented in November 2011.
- The Committee received a copy of the Internal Audit report on the review of the clinical audit process and an action plan to address the recommendations in March 2012.
- Internal Audit issued a significant assurance report on Infection Prevention and Control strategic leadership and a limited assurance report on following up of infection prevention and control action plans. These reports and the action plan to address the limited assurance report were presented to the committee in May 2011.
- Progress with the work to ensure compliance with the NHSLA risk management standards was reported in September 2011 and, following the informal visit by the NHSLA assessor in January 2012, the Committee were advised that a decision had been made to proceed with a level 1 assessment in August 2012.
- The Maternity team reported to the Committee several times during the year on the progress with the preparations for the level 2 CNST inspection in October 2011. The Committee was informed of the successful outcome of the assessment in November and the action plan to address the points identified by the assessors was shared with the group in December 2012.

3.5 Organisational Capability

The Committee has a duty to assure itself that:

> 'The Trust has the organisational capability with regard to its workforce and IM&T systems to deliver its objectives.'

The following reports were received in the year to date:

- Measuring and monitoring data quality report was presented in March 2012.
- Update on workforce risks was presented to the Committee in July 2011 and February 2012 this provided assurance that workforce risks were being identified and managed.
- The committee received several reports relating to the single equality scheme and the monitoring and setting of equality objectives.
- During the course of the year the Committee also received reports on the following key areas:
    - Reports on the levels of staff appraisal and mandatory training were presented in October 2011, these informed the committee about the new reporting process using the ESR system which it is hoped will improve the reporting of these metrics.
    - The committee received a report on sickness levels in the organisation in November 2011

3.6 Other duties

The Committee receives minutes from each of the sub-groups, and provides minutes of its meetings to the Board of Directors each month. End of year reports for the Clinical Standards sub group and the Risk and Assurance sub group were presented to the Committee in April 2012 and the annual report for Organisational Capability sub group was considered in May 2012, it was agreed that the terms of reference of these groups had been met during 2011/12. Committee members were assured that the sub-groups were discharging their responsibilities effectively.

The Committee's terms of reference for 2011/12 include a duty to ensure that there are effective procedures in place to promote governance between organisations. In 2011/12 there have been no reports to specifically address this requirement though compliance with the CQC standards does require good systems in relation to transfer of patients and their records between organisations. This element of the Committee's terms of reference is subject to further discussion.

4. Looking Forward

The Committee will continue its work in accordance with its Business Plan. Future work will include:

- Agreeing the work required to provide assurance in relation to Governance between Organisations.
- Establishing a process to receive assurances that quality is maintained as services are redesigned and productivity and efficiency projects are implemented.
- There is an outstanding requirement to receive assurance on progress towards implementing a new revalidation process

Ruth James
Deputy Director Healthcare Governance and Quality
May 2012.

Appendix 1.

Integrated Governance Committee Annual Business Plan 2010/11				
	Terms of Reference	**Action to meet ToR**	**Lead**	**Date of Action**
13a.	**The Trust's Integrated Governance Strategy is regularly reviewed and updated and its objectives are being delivered in a timely fashion.**			
a.i	Integrated Governance Strategy 2011-13	Receive and review.	R James	Decision not to proceed.
a.ii	Monitor's Quality Governance Framework	Receive gap analysis and agree actions	R James	April 11
		Review implementation of actions	R James	Oct 11
13b.	**The Trust delivers high quality patient centred care, particularly with regard to patient safety, clinical effectiveness and patient experience.**			
b.i	Trust-wide quarterly governance and quality reports	Receive and review, highlight exceptions to Board.	R James.	May 11
				Sept 11
				Nov 11
				Feb 12
b.ii	Quality Accounts 2010/11	Receive and review draft Quality Account for 2010/11	R James.	May 11
		Receive and review final version of Quality Account for 2010/11		Not needed
		Monitor progress against the quality improvement priorities for 11/12.		Nov 11
b.iii	Patient Experience	Monitor progress against the Patient Experience Strategy, including compliance with DSSA.	A Sutcliffe	June 11
				Oct 11
		Receive outcome of review of the complaints process.	R Jamieson-	Mar 12

			Gaffney	
		Receive and review annual complaints report.	R Jamieson-Gaffney	June 11
		Update on discussions with planning re breastfeeding and baby changing facilities	A Smith	May 11
b.iv	Safe-guarding adults	Report from CQC on inspection re patients detained under Mental Health Act.	B Walker	Mar 12
b.v	Clinical audit (see also 13e below)	Review clinical audit forward plan	R James	May 11
		Mid-year review of clinical audit		Dec 11
		Review clinical audit annual report 10/11		May 11
b.vi	NICE guidance	Receive assurance on compliance with NICE guidance and be notified of any non-compliance.	Med Dir	Oct 11
b.vii	National reports - Francis report into Mid-staffs Foundation Trust	Received annual report of Health Records Steering Group	T Hart	July 11
b.viii	Clinical Standards sub-group	Receive and review notes of meetings	Med Dir.	Monthly
13c.	**The Trust complies with regulatory, legal and code of conduct requirements eg. those determined by the Care Quality Commission.**			
c.i	CQC registration	Review Quality and Risk Profile updates (6-monthly and by exception when a standard goes red).	R James	May 11
				Nov 11
				By exception
c.ii	NHSLA registration	Review progress towards level 2	R James	Sept 11
				Feb 12
		Review progress towards maternity level 3		Sep 11
c.iii	NHS Constitution	Receive assurance on compliance with NHS Constitution (annually).	S Watson	Nov 11

		Update on partially compliant standards and pledges (ad hoc)		May 12
c.iv	Outcomes of inspections by regulatory bodies/peer reviews etc.	Receive exception reports and review action plans	Med Dir	Ad hoc
c.v	Information Governance	Receive annual report	N Huntley	July 11
		Receive update on progress with Info Gov Toolkit		Nov 11
				Mar 12
13d.	**The Trust has the organisational capability with regard to its workforce and IM&T systems to deliver its objectives.**			
d.i	Single Equality Scheme and Equality Impact Assessments	Receive assurance on delivery of SES and outcomes of EqIAs.	E Rushmer	April 11
		Update on delivery of SES		Feb 12
d.ii	Workforce risks and workforce issues arising from CQC standards.	Receive assurance that workforce risks are being managed and CQC standards are being met.	Dir of HR	July 11
				Feb 12
d.iii	Appraisal and mandatory training	Receive assurance that appraisal and mandatory training processes are implemented and targets being achieved.	Dir of HR	Oct 11
d.iv	Implementation of the Learning Strategy	Review progress and identify any gaps.	R James	June 11
d.v	Revalidation	Receive assurance on progress towards implementing a new revalidation process	Med Dir	Update due
d.vi	Data quality	Annual reports on data quality and data coding.	J Dewar	March 12
d.vii	Organisational Capability sub-group	Receive and review notes of meetings	Dir of HR	Apr 11
				July 11
				Nov 11
				Mar 12
13e.	**Appropriate systems of risk management and internal control are in place**			
e.i	Corporate risk register	Receive assurance on management of risks on CRR and escalate any concerns to Board.	R James	Monthly

e.ii	Assurance Framework	Receive assurance on management of risks in the assurance framework and escalate any concerns to Board.	R James	Monthly
e.iii	Statement on Internal Control	Review SIC for year 10-11	Dir of Finance	May 11
		Review progress of SIC for year 11-12	R James	Nov 11
e.iv	Internal audit reviews.	Receive outcomes of internal audit reviews (relevant to IGC) and be assured of implementation of recommendations. Review of Clinical Audit received.	Dir of Finance	Mar 12
		Receive Internal Audit Reports on Infection Prevention and Control	Alison Peevor	May 11
e.v	Risk and Assurance Sub-group	Receive and review notes of meetings	T Hart	Monthly
13f.	**Action plans, risk alerts, and lessons learned are disseminated and implemented throughout the Trust, and actively monitored.**			
f.i	NPSA risk alerts	Receive assurance on implementation of risk alerts.	R James (in quarterly governance report)	May 11
f.ii	Learning from complaints and PALS	Review evidence of learning from complaints		Sept 11
f.iii	Learning from clinical audit	Review evidence of action taken to improve care as determined by audit results		Nov 11
f.iv	Learning from incidents	Review evidence of learning from incidents		Feb 12
f.v	Analysis of claims and learning from them.	Annual Claims Report	J Hutchinson	Sept 11
13g.	**Effective procedures to promote governance between organisations are in place**			
g.i	Internal Audit's inter-agency workshops on GBO	Receive a report on the outcomes of this work	S. Fallowfield	TBA
g.ii	Procedures to promote governance between organisations	Receive and review an action plan to develop GBO	TBA	TBA

		Receive and review top 10 areas of care where GBO is important and demonstrate governance arrangements are in place.		
13h.	**Agreed organisational standards and policies are implemented across all clinical and corporate directorates**			
h.i	Organisational policies	Receive assurance that policies are being embedded and implemented within the Trust.	R James	Sept 11
13i.	**Review of Terms of Reference and Effectiveness of IGC and Sub-groups**			
i.i	Annual review of sub-groups	Receive assurance from the sub-groups that they have delivered their aims and objectives for the year:		
		Clinical Standards Sub-Group	R James	April 11
		Risk and Assurance Sub-Group	R James	April 11
		Organisational Capability Sub-Group	Dir of HR	May 11
i.ii	Annual review of work of IGC and sub-groups. Review ToR, attendance and membership. Assess whether IGC and sub-groups have delivered their aims and objectives for the year.	Provide assurance to Board that IGC and sub-groups have reviewed their Terms of reference and delivered their aims and objectives for the year.	H Wallace & R James	May 11

Appendix 2

Integrated Governance Committee Attendance for April 11 – March 12

NAME	Apr 11	May 11	Jun 11	Jul 11	Sep 11	Oct 11	Nov 11	Dec 11	Feb 12	Mar 12	Total
Wallace Ms H	p	p	p	p	p	p	p	p	p	p	10/10
Appleton Mrs G		p									
Dean Dr J											0/10
Duncan Lt Col T											
Elliott, Mrs K			p	p	p	p	p	dep		p	7/8
Ewart Mr G		p	p			p	p	p	p	p	7/10
Hall Dr J											0/10
Harrison, Mr C/HR	dep	dep		dep	dep	dep	dep			p	7/10
Hart Mrs T	p		dep		p	dep	p			p	6/10
Huntley Mrs N			p	p	p		p			p	5/10
Irons Mrs Linda	dep	p	dep	p		dep	p	p	p	p	9/10
James, Ms R	p	p	p	p	p	p	p	p	p	p	10/10
Kenward, Lt Col G					p				p	p	3/6
Newton, Mr C/Finance		dep	dep	dep		dep	dep	dep	p		7/10
Parnell, Mrs C	p										1/10
Singleton Mrs P	p	p		p		p			p		5/10
Tempest Ms L	p	p	dep	p		p	p		p	p	8/10
Thompson Mrs B	p										
Toller Fran		p	p			p	p	p	p	p	7/10
Walker Mrs B		p	p	p	p		p		p	p	7/10

Watson Mrs S	p	p		p		p	p	p			6/10
Wilson Prof R	p	p	p	p		p	p	p	p	p	9/10
Total Present	11	13	12	11	9	13	14	9	12	13	
No. on IGC	20	19	19	19	19	19	19	19	19	19	
% attendance	55%	68%	63%	58%	47%	68%	74%	47%	63%	68%	

p = present
shading = leaving/joining committee
dep = deputy attended
No Aug or January meetings
Quorum=5
Average attendance per meeting for the year = 63%