South Tees Hospitals NHS
NHS Foundation Trust

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

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

Title:	Minutes of the Integrated Governance Committee held on 13 June 2012

Purpose:	A copy of the minutes of the Integrated Governance Committee for connectivity and assurance.

Summary:	Clinical Audit Annual Report – the committee were assured that the clinical audit plan for 2011.12 has been delivered. Clinical Audit Annual Plan – the Clinical Audit Plan for 2012/13 was supported. Update on Revalidation – the committee were assured of progress. 525 doctors need to be revalidated. The trust has now achieved 95-100% of doctors being appraised which is regarded as one of the highest numbers across the region. The only red area identified is around resources. CQC Compliance Report – verbal update received following the inspection by CQC to Women and Children to review documentation for termination of pregnancy. Final report awaited. Annual Complaints Report – the key issues were highlighted and discussed. Annual Report on the Delivery of Patient Experience Strategy – the report was accepted and the committee felt that the results were very positive. Annual Claims Report and Claims Risk Management Initiatives Report – the key issues were highlighted and discussed. Board Assurance Framework and Corporate Risk Register – no new risks required escalation. The notes from the Clinical Standards Sub-Group and Risk and Assurance Sub-Group and the Patient Safety Programme Board were received and the key issues highlighted.

Prepared By:	Mrs H Wallace	**Presented By:**	Mrs H Wallace

Recommendation:	The Board of Directors is asked to receive the minutes.

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

South Tees Hospitals NHS
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MINUTES OF INTEGRATED GOVERNANCE COMMITTEE
Held on
WEDNESDAY 13 JUNE at 3.00 pm
In, The Board Room, The Murray Building, JCUH

PRESENT

Ms	Henrietta	Wallace	Chair/Non-executive Director
Prof	Rob	Wilson	Vice Chair/Medical Director
Mrs	Kath	Elliott	Senior Nurse for Surgery
Dr	George	Ewart	Non-executive Director
Mr	Chris	Harrison	Director of Human Resources
Mrs	Linda	Irons	Chief of Clinical Support Services
Ms	Ruth	James	Deputy Director of Healthcare Governance and Quality
Mrs	Pauline	Singleton	Non-executive Director
Ms	Lisa	Tempest	Community Services Representative
Mrs	Yasmin	Scott	Divisional Manager Representative
Mrs	Bev	Walker	Assistant Director of Nursing/Patient Safety
Mrs	Susan	Watson	Director of Operational Services

IN ATTENDANCE

Mrs	Rachel	Jamieson-Gaffney	Head of Complaints
Mrs	Val	Merrick	Secretariat

1 APOLOGIES FOR ABSENCE

Mr	Stuart	Fallowfield	Audit North
Mrs	Tricia	Hart	Deputy CEO/Director of Nursing/Patient Safety
Mrs	Nicky	Huntley	Information Governance Manager
Lt Col	Gary	Kenward	MDHU Representative
Mrs	Caroline	Parnell	Company Secretary/Executive Assistant to CE
Mr	Chris	Newton	Director of Finance

2 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 9 May 2012 were accepted as a correct record.

3 MATTERS ARISING/ACTIONS

Apr 2012/7 Discuss DATIX for community services in relation to workforce risks – discussion in April identified a need to capture on DATIX workforce risks in the community. Currently being investigated by Kay Davies. Discussion deferred until September.

Apr 2012/2 Update on key recommendations from the Ombudsman Report of investigation of complaint - Clarification of reference to maladministration – Rachel Jamieson-Gaffney explained that this related to terminology that had been used in a response and that this phrase is not used any more.

Apr 2012/6 Organisational Capability Sub Group

- Monitoring of divisions in relation to consultant recruitment timescales – Chris Harrison was not convinced that candidates were being lost due to the timescales and felt that that the current system works well. The requirement for College representation on Appointment Committees was questioned. Rob Wilson's view was that their role in the process was important and offered extra assurance and would prefer to continue. Some members felt that some other trusts were able to speed up

the recruitment process by not requesting College representatives to sit on panels but ask them look at the applications. Rob Wilson responded that we have also occasionally requested an internal advisor to do this when the College hasn't been able to provide a representative.

Action: Prof R Wilson/Chris Harrison/Rachael Metcalf to discuss further.

- Discussion regarding specific organisational capability reports to be presented to IGC in the coming year – Chris Harrison has provided a list of scheduled reports and the months they will be presented.

4 GOVERNANCE REPORTING

4.1 CLINICAL AUDIT ANNUAL REPORT

Summary: Ruth James presented the Clinical Audit Annual Report for 2011/12. She reported that all trust wide audits in the acute setting were carried out during the year, a small number were still in the reporting phase. An audit planned to be carried out by community services has been deferred and is now included in the forward plan for 2012/13, as it has been superseded by a plan to use the EWS system.

Discussion: Ruth James and Rob Wilson are considering measures to improve the reporting of clinical audit. Henrietta Wallace questioned where national audits should be reported and this was discussed. Rob Wilson, Ruth James, Tony Roberts and the specialty all receive reports of national audits which come into the organisation, and they pick up any issues highlighted and actions to be taken including those which will be reported to Clinical Standards Sub-Group. In response to a question regarding implementation of outstanding actions which were identified in the internal audit review of clinical audit, Ruth James explained that the measures to address the recommendations were being piloted and if successful would be incorporated into the Clinical Audit Policy in September.

Agreed: The committee received assurance that the clinical audit plan for 2011/12 had been delivered.

4.2 CLINICAL AUDIT ANNUAL PLAN

Summary: Ruth James presented the Clinical Audit Annual Plan which outlines the comprehensive programme of work planned for 2012/13.

Discussion: A number of audits will be continued from last year. Issues such as grade 3 and 4 pressure ulcers, HCAI and discharge are part of the plan. A large number of audits relate to CQUIN measures. Discharge, sepsis and the Mental Capacity Act and decision making are all part of CQUIN this year. Pressure ulcer audits are clinical audits and prevalence audits are carried out by Huntley with Sharon Bateman. Identifying leads or clinical champions for new audits is in progress.

Agreed: The Clinical Audit Plan for 2012/13 was supported.

4.3 UPDATE ON REVALIDATION

Summary: Rob Wilson updated on the Revalidation of Consultants, Staff Grade, Associate Specialists and Specialty Doctors and Non Training Grade doctors. He summarised the background, explaining that it's based on GMC advice and legislation from January 2011. Each designated body nominates a Responsible Officer who informs the GMC whether a doctor should be relicensed. Process is based on appraisal and the policy covers all aspects:

- Quality and assurance of the process
- Who should be carrying it out
- Nationally validated appraisal training programme
- Advice on how many appraisals appraisers should be doing

525 doctors need to be revalidated. Two years ago 70% of doctors had been appraised within 15 months. The trust has now achieved 95-100% which is regarded as one of the highest numbers across the region. The revalidation process will require yearly appraisals with a

strengthened appraisal every 5 years, including 360 degree feedback by colleagues and a patient exit poll. Four people have been through Responsible Officer training. ORSA (Organisational Readiness Self-Assessment) forms the basis of the trust gap analysis. The only red area identified has been for resources which so far has been addressed in the following ways:

- Resourced in the office at the moment with reorganisation of roles. Sue Wooding has moved into the role of Revalidation Officer.
- Associate Medical Director who has responsibility payment but no allocated time.
- Externally funded post for 1 year
- Admin help through the National Revalidation Support Team.

The proposal is that in the first year doctors with management and leadership roles and the Responsible Officer should be revalidated towards the end of this year and the remainder of doctors in the middle 3 years. The final year will be used to repeat any if needed. If there are issues review could be more frequent. The organisation is regarded by GMC as one of the best in terms of readiness.

Discussion: Lisa Tempest questioned revalidation for GPs and Rob Wilson informed that he and Richard Rigby, Associate Medical Director for Community Services, meet regularly and that our responsibility will be limited to GPs employed by the organisation and locums will be covered by their agencies. In response to questions around maintaining appraisal skills Rob Wilson felt that appraisers should carry out at least 5 a year but no more than 10.

Agreed: The committee accepted the report and were assured of progress.

Actions:	**By:**	**Deadline:**
Annual report on revalidation to IGC	Prof R Wilson	June 2013

5 CARE QUALITY COMMISSION

5.1 CQC COMPLIANCE REPORT

Summary: Ruth James gave a verbal update following the inspection by the CQC to Women and Children to review documentation for termination of pregnancy. A previous update to IGC informed on issues raised around some of the documentation, and the team have put in measures to address this and are auditing compliance.

The formal report from the CQC has now been received and has found that the service is fully compliant and no action is required.

Ruth James updated that an unannounced CQC inspection took place at Guisborough Primary Care Hospital on 12 June. CQC undertake a series of unannounced visits; they inspected JCUH in January and plan to inspect every location every year. Bev Walker and Lisa Tempest supported staff on the ward on the day of the visit and Ruth James and Jackie Robinson are collating the documentary evidence required. Bev Walker reported that verbal feedback on the day was very positive but we need to await the full report. This is recognition of the work undertaken over the last few months on Priory Ward to address some of the staffing issues there, and feedback from staff is now much more positive. A very good ward manager and 2 new community matrons have been appointed to support the work and development of nurses in community services.

Actions:	**By:**	**Deadline:**
Exception report and action plan to IGC following receipt of final CQC report.	Ms R James	When Available

6 QUALITY OF CARE AND PATIENT SAFETY

6.1 ANNUAL COMPLAINTS REPORT

Summary: Rachel Jamieson-Gaffney presented the Annual Complaints Report and summarised the main areas.

Discussion: 326 formal complaints had been received during the year 11-12. In the last 5 years numbers remained static for 2008/9 and 2009/10 but have increased slightly year on year from 2009/10. Acute Medicine received the largest number of formal complaints but is considered to be in line with levels of activity. Formal complaints show a decrease in relation to discharge of patients and care of the dying. Increases have been seen around missed or delayed diagnosis and a further review of these complaints is taking place. Number of formal complaints reopening has decreased to 70 this year compared to 86 for 2010/11 and no specific trends in divisions were identified. PALS enquiries remained fairly static over the year with the biggest trend being around admission, surgery and cancellations. Of the 326 formal complaints, 71 had no action identified, 165 had actions identified. Performance in providing evidence to show that actions have been implemented doesn't appear to have improved. Ruth James stated that the process for reviewing action plans needs to be revisited and will be discussed with Divisional Managers and Governance Leads.

The NHS Information Centre is now requiring that information be submitted annually on the outcome of complaints, and outcome codes are provided by divisions for each complaint. This is the first year of data submission and information recorded to date shows that 12% of complaints have been substantiated, 44% partly substantiated and 42% unsubstantiated.

For completeness, in the section on complaints to the PHSO, Henrietta Wallace requested that some brief information be included about the one Ombudsman investigation which was completed in the year.

It was recognised that the organisation also receives a large number of compliments during the year.

Agreed: The committee received the report.

Actions:	**By:**	**Deadline:**
Discuss Action Plan Process with Divisional Managers and Governance Leads.	Ms R James	September 2012

6.2 NOTES OF PATIENT SAFETY PROGRAMME BOARD

Summary: Bev Walker highlighted the key issues from the meeting held on 23 May 2012.

NMP Research – Lynne Paterson, Nurse Consultant, has been carrying out research into medication errors by both medical and nursing staff, and improving patient safety through encouraging and supporting reporting of medication incidents. Issues were discussed around the training of junior medical staff. Education needs to be constant for prescribers.

Safer Medication Practice Group – low attendance was highlighted. It was agreed that the group would be reviewed, the Terms of Reference updated and that it would be chaired by a pharmacist and supported by a clinician as vice-chair.

CQUIN Safety Thermometer Update – report on progress on the rollout of the Patient Safety Thermometer. Over 6000 patients have been surveyed since December 2010 (800 per month since February) and 80-85% of wards now submit data. Community Services have also started to submit. 93% of patients surveyed are experiencing harm free care. Intentional rounding has been introduced. Some concern was expressed about the level of understanding of the harm free care agenda across the trust and staff were asked to discuss this in their divisions.

Patient Safety Education – Dave Murray delivered a presentation on Patient Safety Education.

Discussion was around use of scenarios. David Reaich and Dave Murray will investigate possible improvements with the use of scenarios.

6.3 NOTES FROM CLINICAL STANDARDS SUB GROUP HELD ON 22 MAY 2012

Summary: Professor Wilson highlighted the key issues from the meeting held on 22 May.

The North of England Palliative Care Guidelines were presented and approved. The Deciding Right document has been well circulated across the region and is multidisciplinary in its focus. The aim is to achieve consistency in palliative care throughout the north.

A new procedure for minimally invasive thoracic surgery was presented. A new doctor is most experienced in this technique and has published 3-4 papers.

6.4 ANNUAL REPORT ON THE DELIVERY OF THE PATIENT EXPERIENCE STRATEGY

Summary: Bev Walker presented the Patient Experience Progress Report on behalf of Anne Sutcliffe and updated on activities being undertaken in relation to the Patient Experience Strategy which was launched in May 2010. A range of methods to obtain feedback from patients have been used, including paper and on-line surveys, the national survey, face-to-face discussion, focus groups and a patient experience event and another is due at the end of June. Patients and the public are receiving feedback in a variety of ways on actions taken as a result of their experiences

Discussion: Bev Walker explained that the strategy was developed by the Trust lead for patient experience and matrons working with patients. Patients are invited to take part in on-line surveys through a system funded by the PCT with variable response; some areas have achieved good response rates but some patients don't want to take part. It is very important to obtain feedback on patients' experience at the interface and on-line real-time feedback is very helpful. The trust has been involved in the 2011 National Outpatient Survey, which is compulsory and scored highly for many of the questions. The results for 23 of the 30 questions placed the trust in the top 20%. Some scores were lower in 2011 but not significantly. Although results are generally good, there are some key areas which could be focused on to make improvements, including:

- Waiting in departments – ensuring that patients receive information if their wait is more than 30 minutes and receive apologies from staff for excessive delays.
- Staff introducing themselves to patients and explaining their role.
- Medications – ensuring that patients receive information and explanations about the medication they are given.
- Ensuring a consistent approach to copying letters to GPs to patients.

Divisions have been asked to monitor compliance

National Inpatient Survey - The CQC has responsibility for the National Inpatient Survey and is part of the National Patient Safety Programme. The annual survey is one of the methods used to benchmark the trust in comparison to other organisations. Five questions have been included which relate to CQUIN and are designed to measure improvement. Overall the results are very positive with the trust performing the same as other organisations. The majority of lower scores relate to communication with patients including providing written information about care and treatment or explanations from staff. More information may need to be given about same sex accommodation. Results should be shared with patients and the public. Divisions are being asked to discuss in quarterly performance reviews what actions they are taking as a result. Questions relating to nursing should be discussed in NMPPG and questions relating to doctors should be discussed at the Chief of Service meeting in June. Susan Watson added that the National Cancer Survey has just closed and the results will be available in July. It is planned to run the patient experience event every 6 months and the second event is due to take place at the FHN in July.

Agreed: The committee accepted the report and felt that the results were very positive,

7 RISK AND ASSURANCE

7.1 REVIEW OF THE BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

Summary: Ruth James presented the Corporate Risk Register and the Board Assurance Framework. No new risks require escalation.

Agreed: No new risks require escalation.

7.2 NOTES FROM THE RISK AND ASSURANCE SUB GROUP

Summary: Ruth James highlighted the key issues from the Risk and Assurance Sub Group held on 12 June 2012.

Divisional Risk Presentations – A presentation was received from Clinical Support Services. Discussion around aseptic pharmacy. An issue was noted around providing medication reconciliation which is a CQUIN measure. This is a process of checking that patients' existing medicines are reflected in medicine charts and that any changes made are included in discharge summaries. Sath Nag is the lead for this measure for the trust.

Quarterly Maternity Report – The maternity team presented their quarterly report on significant incidents and risk register. No concerns were raised by the team. The team have undertaken a local gap analysis of the supervision of midwives which took place at Morecambe Bay and have not found any significant issues.

Safeguarding Children – Helen Smithies presented a report on the requirements around safeguarding children training. Training Needs Analysis will need to be reviewed to include safeguarding training.

Bev Walker presented following the joint CQC/Ofsted inspection at Redcar and Cleveland around safeguarding children and how children in care are managed. Helen Smithies had reported that initial feedback suggests that we have scored well for both safeguarding services and looked-after children, but there may possibly be some recommendations around governance for looked-after children which has been discussed with Bev Reilly, Associate Director/Board Nurse, NHS Tees. Final written report is awaited.

Complaints Annual Report and the Claims Annual Report were discussed.

Business Continuity Report Including Overview of Olympics 2012 – Donna Jermyn updated that progress on the requirement was slow and is currently on the Corporate Risk Register but is due for review in August. She also briefed on business continuity arrangements around the Olympics and torch relay, road closures, etc.

7.3 ANNUAL CLAIMS REPORT AND CLAIMS RISK MANAGEMENT INITIATIVES REPORT

Summary: Julia Hutchinson presented the Annual Claims and Claims Risk Management Initiatives Report and summarised the key issues.

Discussion: Last year's report revealed a 100% increase in clinical and non-clinical claims compared to the previous year. This year the rate of increase has slowed to about 8%. Staff are under pressure from new notifications. There were 120 new claims in the year. Compared to last year fewer claims relate to medical treatment as opposed to surgical management and infection but there has been a slight increase in those relating to failure or delay in diagnosis. 36 claims were settled (39%). The majority of claims continue to be managed in house under the NHSLA delegated authority with the more expensive claims handled by NHSLA and the trust has no influence over whether these claims are defended or settled.

44 non-clinical claims were closed last year. Acute Medicine had more non-clinical claims,

reasons are uncertain but maybe due to the number of assault and sharps injuries and slips and trips. The majority of non-clinical claims relate to sharps injuries. Despite a range of actions the numbers of these are not reducing, with some employees reporting multiple injuries. NHSLA view these claims as employer liability and the organisation has to pay. Conflict Resolution training also needs to be assessed.

New claims are being reviewed at notification stage. Divisions are being encouraged to use a multi-disciplinary approach and to identify whether actions are needed. Documentation is the main issue and there is a lack of evidence that information leaflets have been given out during the consent process. The NHSLA risk management initiative started last year, requiring trusts to report annually on risk management issues that their solicitors have highlighted. The trust submitted a report on the 16 claims the NHSLA solicitors had identified. 281 organisations responded. The conclusion is that this will not be repeated annually and it is planned to include risk management into the NHSLA risk standards process.

In response to questions relating to the number of claims (clinical and non-clinical) in Acute Medicine, Yasmin Scott expressed concern about failure or delays in diagnosis and also the number of sharps injuries. She has discussed the issues with a range of staff. With regard to sharps injuries, we are an outlier in the region but investigation of other organisations' preventive measures had revealed no differences in our practice.

Agreed: The committee received the report and agreed that the number of sharps injuries involving individuals making multiple claims needs to be addressed. It was agreed that Henrietta Wallace would obtain advice from Graham Thompson, Audit North, who is a member of the Audit Committee.

Actions:	**By:**	**Deadline:**
Obtain advice from Graham Thompson regarding preventative measures for sharps claims.	Mrs H Wallace	ASAP

8 ORGANISATIONAL CAPABILITY - None

ITEMS FOR INFORMATION

9. ANY OTHER BUSINESS none

10. CONNECTIVITY - none

11 DATE AND TIME OF NEXT MEETING

The next meeting will be held on Wednesday 11 July 2012 in The Board Room, The Murray Building, JCUH.

The meeting closed at 4.55 pm