South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	27 August 2013

This paper is for:	Action/Decision	Assurance X	Information

Title:	Minutes of the Integrated Governance Committee held on 10 July 2013

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

Summary:	Review of Compliance with Monitor's Framework for Quarterly Declaration - the committee agreed that compliance could be declared for quarter 1. Update on NHSLA Declaration – NHSLA assessment against risk managements standards will cease. Annual fees will be based on claims history. Decision will be made following informal assessment whether CNST assessment against the maternity standards will go ahead in early 2014. Changes to the Quality Governance Structure – It was agreed that wider consultation in the organisation was required about the proposed changes. Outcome of External Audit Report on the Quality Account – the auditors have given full assurance on the limited elements inspected. Annual Report for Clinical Audit and Forward Plan – accepted. Annual Report on the Delivery of the Patient Experience Strategy - progress against the patient experience strategy was noted. Update on Quality Impact Assessment – a QIA process has now been implemented and all CIPs assessed against it. PHSO Action Plan – key issues were discussed. Annual Report on the Risk Management Strategy – performance indicators have been fully met. Corporate Risk Register – following discussion 1 risk to be escalated to board. Annual Report on Data Quality and Coding – progress against the standards was noted. Recruitment Update – significant improvement was noted. The key issues from the notes of the Clinical Standards, Risk and

	Assurance and Organisational Capability Sub Groups were discussed.

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

South Tees Hospitals NHS
NHS Foundation Trust

MINUTES OF INTEGRATED GOVERNANCE COMMITTEE
Held on Wednesday 10 July 2013
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
Mr	Chris	Harrison	Director of HR
Mrs	Mandy	Headland	Divisional Manager for Community Services
Mrs	Nicky	Huntley	Information Governance Manager
Mrs	Linda	Irons	Chief of Clinical Support Services
Major	Ruth	Truscott	MDHU Representative
Ms	Ruth	James	Deputy Director of Healthcare Governance and Quality
Mrs	Yasmin	Scott	Divisional Manager Representative
Mrs	Susan	Watson	Director of Operational Services

IN ATTENDANCE

Mrs	Alison	Davis	Head of Information Services for item 8.2
Ms	Lynne	Hart	Data Quality Team, Leader for item 8.2
Mrs	Sandra	Donoghue	Divisional Manager for Surgery for item 6.3
Mrs	Linda	Oliver	Patient Experience Co-ordinator for item 6.1
Mrs	Emma	Carter	Clinical Governance Manager for item 4.2
Mrs	Val	Merrick	Secretariat

1 APOLOGIES FOR ABSENCE

Mrs	Ruth	Holt	Director of Nursing
Mrs	Caroline	Parnell	Company Secretary/Exec Assistant to CE
Mr	Chris	Newton	Director of Finance
Mrs	Pauline	Singleton	Non-executive Director
Mr	Stuart	Fallowfield	Audit North

2 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 12 June 2013 were accepted as a correct record

3 MATTERS ARISING/ACTIONS

May 2013/3 Update on partially compliant pledges and standards from the NHS constitution – Rob Wilson confirmed with Joanne Dewar that supply of clinic letters to patients will be an onsite process.

June 2013/3 Annual claims report – Ruth James to discuss claims review with Julia Hutchinson

4 GOVERNANCE REPORTING

4.1 Review of Compliance with Monitor's Framework for Quarterly Declaration

Summary:
Ruth James updated on the gap analysis to inform the Quarter 1 declaration to Monitor.

Discussion: Previous review of compliance identified one outstanding action relating to Quality Impact Assessment of proposed cost improvement programmes. This has now been addressed with the implementation of an in-house system using ASPYRE software. The trust is now fully compliant.

Agreed: The committee agreed that compliance could be declared for the quarter 1.

4.2 Update on NHSLA Declaration

Summary: Emma Carter updated on developments with the NHSLA standards.

Discussion: The NHS Litigation Authority has written to the trust to advise that it will no longer assess against the risk management standards and will in future base the calculation of the level of annual contribution on an organisation's claims' history. CNST maternity standards are continuing for this year and our maternity team has an informal assessment scheduled for 30 August 2013 and assessment on 25 and 26 February 2014. The NHSLA have asked the trust to confirm that the organisation wishes to go ahead. We have responded to say we will make a decision following the informal assessment in August. Work continues to reduce the number of claims by identifying improvements, including thematic analysis. Patient safety walkabouts should help with gathering information and inform the current position.

General discussion around ensuring that momentum is kept up to maintain good risk management processes across the trust including measures to ensure the highest standards of record keeping are maintained. Ruth James confirmed that this is covered by clinical audit and the patient safety walkabout record keeping audit should strengthen this. General agreement that this could be an opportunity to focus more on local priorities.

Agreed: The committee accepted the update and was assured that this was a good way to progress.

Actions:	**By:**	**Deadline:**
Feedback from the maternity informal assessment to come back to the committee	Mrs Fran Toller	September 2013

4.3 Consultation on Proposed Changes to the Quality Governance Structure

Summary: Ruth James presented the proposals for the revised governance structure for consultation.

Discussion: Ruth James explained that Monitor, the National Quality Board and the Department for Health have issued guidance on what should be included in an organisation's governance structure. Ruth James summarised the requirements in the guidance, highlighting the areas not currently covered by the existing governance structure and the proposed changes. These were discussed in detail. Proposed changes include:

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1. Integrated Governance Committee to become the Quality Committee (QC) – picking up duties previously covered by the Risk and Assurance Sub Group including analysis of themes arising from complaints, claims and incidents.

2. Risk and Assurance Sub Group to be disbanded and its duties covered by other groups and committees.

3. The Patient Safety Programme Board to become the Patient Safety Sub group.
4. Establishing an SUI review group
5. A Patient Experience Sub-group to be established for in-depth review of patient experience feedback, complaints and PALs and chaired by or including a NED.
6. The Organisational Capability Sub Group to become the Workforce Sub-Group. 3 options were offered for consideration.
7. Formal Management Group to receive actions from Performance Reviews.
8. Quality Assurance walkabouts to replace Patient Safety Walkabouts and will include CQC type spot checks of documentation and records, etc.

Linda Irons was concerned about the wording around AHPs. Yasmin Scott felt that there was an issue around dissemination of information from SUIs and how that influences changes in practice across the trust.

Chris Harrison felt that changes to Organisational Capability Sub Group should help and will require pulling together information from several groups to cover workforce issues.

Henrietta Wallace felt that the focus on patient experience and the involvement of NEDs on that group was a necessary change and Rob Wilson agreed that the patient safety element is very valuable.

Rob Wilson felt that the requirement for reporting relating to medical training and development needed further discussion before the proposals progressed through to Audit Committee.

The consultation process and progress through the committees was discussed in detail. Rob Wilson asked for further consultation to be delayed until more detail was available on reporting processes around medical training, and this was agreed. Yasmin Scott, Henrietta Wallace and Kath Elliott felt it would be useful, in addition to Corporate Directors, for NEDs, Chiefs, Senior Nurses and Divisional Managers to have sight of the proposals and be able to comment, with the intention of proceeding to Audit Committee in September and Board in October. The expectation would be to implement the new structure by the end of 2013.

Agreed: The committee accepted the proposals and agreed to proceed with consultation once the issue around reporting of medical education had been resolved. The proposed new structure would be presented to Audit Committee in September and Board in October.

Actions:	**By:**	**Deadline:**
1. Update on progress to IGC 2. Circulate the proposals for wider consultation before taking the proposals to Audit Committee in September	Mrs R James	11 September 2013

4.4 Outcome of External Audit Report on the Quality Account

Summary: Ruth James informed on the outcome of the external audit report for the 2012/13 Quality Account. The auditors gave an unqualified limited assurance report in respect of the Quality Account.

Discussion: In addition to the audit of the Quality Account, Monitor require the auditors to undertake testing of a further mandated indicator. For quarter 1 the indicator was the "percentage of patient safety incidents resulting in severe harm or death".

They checked that the information we had in our Quality Account was the same as our local data. Three errors and 1 control issue were identified in the sample tested. There were three more incidents in this category uploaded to the national system than are recorded on DATIX. This is due to some maternity incidents being reported at higher severity initially and then

downgraded following investigation. A process review is being undertaken and a Root Cause Analysis tool will be developed for maternity. In the meantime, incidents will not be uploaded where there is likely to be change until they have been checked. A note has been added to the wording of the Quality Account to that effect. The auditors have given full assurance on the limited elements they have inspected.
Agreed: The committee agreed this was a positive result and received assurance.

4.5 Annual Report for Clinical Audit and Forward Plan

Summary: Ruth James highlighted the key issues for the planned clinical audit programme for 2013/14.

Discussion: Ruth James updated that last year's plan had been met. Blood transfusion in the community is shown as amber and is being followed up with community hospitals and clinical leads.

The Annual Plan for 2013/14 shows the trust-wide and national priorities for audit. Evidence of delivery of objectives some of which link with requirements for CQUIN, NHSLA and NICE guidance. National audits are run and monitored in the divisions with the Clinical Audit team reviewing any that may be of concern. A number of audits are around NICE compliance.

In response to questions around progress with the areas identified as exceptions in the report:

- Linda Irons updated that medicines reconciliation cannot be implemented due to lack of resources. A newly appointed pharmacist has been asked to review workforce gaps, looking at the need for 7 day working in pharmacy and areas in greatest need of medicines reconciliation. Rob Wilson felt that e-prescribing would help alleviate the problem but this is dependent on the financing of the Transforming the Care we Deliver Programme being agreed.

- A number of areas have been identified for improvement relating to resuscitation following cardiac arrest. Yasmin Scott felt that the new criticial care outreach team, which is currently being recruited, should have a positive impact on outcomes. They are expected to be operational by the end of the year following a 3 month training programme. Appropriate escalation and making sure that End of Life care is optimal is critical for achieving improved outcomes. Frequency of monitoring and reporting was questioned and discussed. Yasmin Scott responded that the resuscitation team carry out audits, EOL is monitored monthly and the Critical Care Board monitor outcomes for unexpected admission, to ITU, failure to escalate etc. Furthermore, the success of the new critical care outreach team will also be measured.

Agreed: The committee accepted the report and the forward plan, and requested an update on critical care outreach and resuscitation outcomes a year from now.

Actions:	**By:**	**Deadline:**
Feedback to IGC including update on critical care outreach.	Mrs Y Scott	July 2014

5 CARE QUALITY COMMISSION – none

6 QUALITY OF CARE AND PATIENT SAFETY

6.1 Annual Report on the Delivery of the Patient Experience Strategy

Summary: Linda Oliver, Patient Experience Co-ordinator, informed on progress with the Patient Experience Strategy which was launched in May 2010.

Discussion: A wide range of methods have been used to gather patient experience feedback, including face to face discussion and on line surveys, and information from complaints and PALS and more recently the Friends and Family Test which has been implemented across all inpatient wards, A&E and Maternity. Friends and Family test has replaced the Meridian system which ended in March 2012. Some non-recurring funding has been secured to facilitate roll out of real time data capture. The focus is on areas not covered by the Friends and Family Test. The quarterly in-patient survey can also be modified to capture data relating to areas of particular interest. Essence of Care monthly benchmarks are undertaken involving patients and staff using a wide variety of activities and groups. The profile of the patient experience continues to be raised with staff, patients and the public with feedback through Board, FMG, through the internal governance structures and is accessible to all staff and this month on the trust website.

For 2013/14, development of robust mechanisms is on-going and includes the development of an annual programme for patient experience to reflect recent feedback and national and local objectives. There are quarterly reports to IGC in line with CQUIN requirements.

Over the last year the trust has participated in the Real Time Patient Videos Project. Videos developed within the trust were well received by staff and are available on the trust intranet. A patient experience video toolkit has been developed and has been well received across the organisation as a good training tool. This has also been shared locally and nationally and has been well received by other trusts. The sharing of the toolkit was questioned and discussed. Kath Elliott agreed that the video is a powerful training tool.

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Volunteer involvement to help capture patient experience information will also be explored this year. A service improvement database is being developed. The organisation is engaging with Local Healthwatch membership and external agencies. Relationships are being developed as it takes on new functions.

As part of the complaints review, 100 questionnaires were sent out to complainants. 28 were received reflecting both good and bad experience. A focus group was held with patients who indicated that they would be interested in being more involved.

A robust and systematic process needs to be developed for capturing feedback including to patients via the website.

A business case is required for resources to progress with real time patient experience data capture. The reporting process was discussed and it was agreed to continue to report to IGC.

Linda Oliver agreed to discuss with IT staff development of the trust website as a focus for patient feedback, and with individual wards about displaying information for patients and relatives to see.

Agreed: The committee congratulated teams on the positive progress made with delivery of the strategy over the last year.

Actions:	**By:**	**Deadline:**
Discuss with IT staff website	Mrs L Oliver	ASAP

6.2 Update on Quality Impact Assessment 2013/14

Summary: Ruth James updated on the key issues from the Quality Impact Assessment of the 2013/14 CIP

Discussion: Monitor require trusts to have a QIP process in place. QIA processes have been implemented and all existing CIPs have been subject to QIA. New software is being rolled out in the organisation. Until it is fully operational an in-house tool will be used to record the QIA. The system was trialled in a couple of divisions before going ahead. Meetings have taken place with Divisional Managers to look at cost improvement plans and complete timetables. Round table discussions have taken place with divisional teams. CIPs have been discussed and a number of those have been told not to proceed as they are too high risk. No risks rated red are progressing and amber risks will be monitored through divisional risk registers. Two CIPs were shown as amber. Consultant appointments are being made in Elderly Care and Neurosciences which may have some impact.

The Medical Director, Director of Nursing and Director of Finance and the Deputy Director of Quality Assurance met with commissioners in May to review the process for QIA. The commissioners RAG rated "the level of detail and accuracy of plans" as green and "the standard of evidence supporting the quality impact assessment" as amber. Further monitoring by the commissioners is expected to be through the quarterly Clinical Quality Group.

A system has been set up for monitoring medical productivity. Information is being transferred into the PAO software which will enable reports to be generated and divisions can update plans as they progress. Henrietta Wallace was concerned about monitoring amber risks and Ruth James agreed to bring an update to IGC on monitoring in 6 months.

Agreed: The committee accepted the report and agreed to follow up these two issues.

Actions:	**By:**	**Deadline:**
Update to IGC on monitoring of risks	Ms R James	January 2014

6.3 PHSO Action Plan ST 141-09

Summary: Sandra Donoghue, Divisional Manager for Surgery, provided an update on progress against the recommendations received from the Parliamentary Health Services Ombudsman (PHSO) concerning one complaint.

Discussion: The multidivisional complex complaint was upheld by the PHSO. Investigation found that:

- There was service failure at various points in the patient pathway.
- Maladministration of the complaints process
- A number of lessons learnt which have resulted in change in the division.

In accordance with the PHSO recommendations the requirements have been met within the specified timescales. The complainant was provided with an apology for identified failings and compensation, the trust provided details to the PHSO and complainant of lessons learnt and actions taken to avoid the service failure and maladministration in the future. The action plan has been further updated.

Substantial work has been carried out in the division around the complaints process and how it is monitored, action plans and how information on lessons learnt is fed back. Following review the complaints process has been streamlined, there is a weekly meeting with the Chief of Service, Divisional Manager, Senior Nurse and the Patient Relations team (PRD), weekly meetings between Senior Nurse and PRD and processes for communication and escalation of delays within the division. The process is still evolving.

The issue around service failure around the colorectal MDT did not just involve the surgeon but also the interface between the gastroenterologists and guidelines from the British Society of

Gastroenterologists. Discussions have taken place with the Medical Director, Divisional team, and MDT. The consultant involved has taken on board lessons learnt; discussions have taken place with the relevant people and he has undertaken a written reflection to be included in his appraisal.

It was agreed that sometimes where the complaint is complex and multidivisional it can be difficult to identify where leadership for managing the process lies. Sandra Donoghue said that the response to questions is sometimes unclear and sometimes doesn't answer the specific questions that the complainant is asking. Rob Wilson agreed that in this case, the questions in the initial complaint were not answered sufficiently at the start. It was noted that no further communication had been received from the complainant.

Sandra Donoghue felt that this review had been useful for the division to review its complaints processes and monitoring actions. Sharing information with other divisions was questioned and discussed.

Agreed: The committee accepted the report and was assured that the PHSO's recommendations had been implemented as required.

6.4 HCAI Exception Report

Summary: Not discussed.

6.5 Notes from the Patient Safety Programme Board

Summary: The notes from the Patient Safety Programme Board held on 30 May 2013 were received for information

6.6 Notes from the Clinical Standards Sub Group

Summary: Rob Wilson highlighted the key issues from the meeting held on 21 May 2013. The meeting scheduled for June was cancelled. Dr David Reaich, Consultant Nephrologist, presented the report on NHS Organ Donation. The figures for JCUH were excellent and a number of clinicians are involved. The introduction of the National Early Warning System (NEWS), which is important in reducing harm, was discussed.

7 RISK AND ASSURANCE

7.1 Review of the Corporate Risk Register

Summary: Ruth James highlighted the key issues and these were discussed in detail.

A recent SUI and actions being implemented was discussed in detail. A new risk relating to recognising the deteriorating patient was identified for escalation.

Agreed: The committee agreed that 1 new risk required escalation**.**

7.2 Notes from the Risk and Assurance Sub Group

Summary: Ruth James highlighted the key issues from the meeting on 3 July 2013.

A review of trust policies on the intranet has identified that 74 are out of date. Ruth James will be writing to all policy owners asking them to update as soon as possible or they will be removed from the intranet.

7.3 Annual Report on the Implementation of the Risk Management Strategy

Summary: Ruth James presented the annual review on the implementation of the Risk Management Strategy. This will need to be revised to reflect the new governance structure once it is finalised.

The key performance indicators have been fully met for 2012/13.

Agreed: The committee were assured that the performance indicators have been fully met.

8 ORGANISATIONAL CAPABILITY

8.1 Notes of the Organisational Capability Sub Group

Summary: Chris Harrison highlighted the key issues from the meeting held on 20 June 2013.

A lengthy debate took place around dementia training to be included in the mandatory training programme. It was felt that there would need to be a separate programme. The dementia strategy is being progressed and will be included in the debate.

Workforce performance was discussed in detail. Workforce risks and planning and workforce development were discussed. An internal bank for HCAs is being developed. The need to manage workforce numbers was highlighted and also the need to take account of the Cavendish report and identify how to take it forward.

The staff survey was discussed. Results and actions are being discussed within divisions. Planning for the 2013 is required.

8.2 Annual Report on Data Quality and Coding

Summary: Allison Davis, Head of Information Services and Lynne Hart, Data Quality Team Leader, presented the annual report on data quality and coding.

Discussion: There are two areas, clinical coding and non-clinical coding. The organisation has been subject to external audit on 6-7 occasions with the exception of 2010. 2012/13 results were included in table 1 of the report. With the exception of primary procedure coding at JCUH and secondary coding at FHN the organisation was above the national standards for coding for coding quality.

In a comparative analysis, internal audit showed that 37 specialties were audited in 2012-2013 and cumulatively the trust was above the national standard for coding. Improvements have been seen in the levels of specialties achieving national coding standards with only 22% achieving the standards in 2010 increasing to 75% in 2012-2013, a significant improvement for the Trust.

The Information Governance Toolkit has 3 standards relating to clinical coding and scores show we are compliant at level 2. Data Quality of Patient Admission Systems – there are a number of standards to measure. Information is sent to the dashboard data repository and measures on completeness of data are provided. The organisation compares favourably at a national level.

There are 8 indicators around non-clinical data. 6 are at level 2 and 2 at level 3. There are a number of data quality indicators within CHKS and the trust compares favourably against peer groups within the North East.

Alison Davis stated that over the last 12 months good progress has been made. Community Services is a key area for 2013/14 and work continues with Mandy Headland looking at the systems in use in the community and trying to align how data is captured and shared.

Agreed: The committee received assurance regarding the standard of data coding this year.		
Actions: Annual report to IGC	**By:** Allison Davis / Lynne Hart	**Deadline:** July 2014

8.3 Recruitment Update

Summary: Chris Harrison updated on the improvements to the centralised recruitment service since September 2012

Discussion: It was identified at that time that temporary resources would be needed to meet the increase in activity levels and meet timescales. Additional staff have been recruited and a number of improvements have been made to the recruitment process, including reviewing the process and tracking for Disclosure and Barring Service checks. DBS forms go back to the individuals rather than the organisation and prospective employers can electronically check that forms are up to date. If they are not, a new one has to be requested by the employer and are required to pay a fee. A report is being prepared for discussion at board.

To reduce the volume of activity with nurse recruitment, generic recruitment is being reviewed and is being tested with nurses and fed back into value based recruitment and if it works will be rolled out. Currently there are differences in the recruitment processes for medical and non-medical recruitment and work is continuing to develop a single approach and developing service line agreements with divisions and directorates to determine quality standards and timescales for recruitment.

Chris Harrison reported that significant improvement has been made over the last few months but that the case in terms of resources needs to be progressed. Linda Irons noted that frustration is around the limitations of the NHS jobs website. In response to questions regarding responsibility for paying DBS initially and paying an annual fee, Chris Harrison replied that initially the trust pays but there is uncertainty about whether this can continue.

Agreed: The committee accepted the update and noted that good progress is being made with the recruitment process.

ITEMS FOR INFORMATION

9. ANY OTHER BUSINESS - none

10. CONNECTIVITY

11 DATE AND TIME OF NEXT MEETING

The next meeting will be held on Wednesday 11 September 2013, in the Board Room, The Murray Building, JCUH.

The meeting closed at 5.10 pm