South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	24 April 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 14 March 2012

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

Summary:	Information Governance Toolkit – Final Submission – update received on progress prior to submission on 31 March 2012. A score of 75% is predicted and actions have been implemented for the two areas which are non-compliant. Action Plan to Address the Internal Audit Recommendations Arising from the Review of Clinical Audit – the committee supported the actions proposed to address the recommendations. Annual Review of NICE Guidance Update – the key issues and the actions taken were highlighted. The report showed that the trust was compliant with guidance issues up to March 2011. CQC Feedback MHA – In line with the Mental Health Act, a site visit was undertaken recently. Feedback was generally positive. Formal report will be received by IGC when available. Outcome of Complaints Process – update received following the pilot study into the revised complaints process. A number of negative aspects were highlighted and after consultation, 10 recommendations were agreed. Review of Board Assurance Framework and Corporate Risk Register – following discussion it was agreed that no risks required escalation. Notes from the Clinical Standards Sub Group, Risk and Assurance Sub Group and Organisational Capability Sub Group were received and the key issues noted. Measuring and Monitoring Data Quality – key issues were summarised and assurance was received that the quality of clinical and non-clinical coding is improving.

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 14 March 2012 at 3.00 pm
In Meeting Room 1
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 HR
Mrs	Tricia	Hart	Deputy CEO/Director of Nursing/Patient Safety
Mrs	Nicky	Huntley	Information Governance Manager
Mrs	Linda	Irons	Chief of Clinical Support Services
Lt Col	Gary	Kenward	MDHU Representative
Ms	Ruth	James	Deputy Director of Healthcare Governance and Quality
Ms	Lisa	Tempest	Community Services Representative
Mrs	Fran	Toller	Divisional Manager Representative
Mrs	Bev	Walker	Assistant Director of Nursing/Patient Safety

IN ATTENDANCE

Ms	Alison	Davis	Information for item 8.1
Ms	Gillian	Brown	Information for item 8.1
Mrs	Rachel	Jamieson-Gaffney	Head of Patient Relations for item 6.1
Mrs	Val	Merrick	Secretariat

1 APOLOGIES FOR ABSENCE

Dr	Jeremy	Dean	Chief of Radiology
Dr	Jim	Hall	Associate Medical Director
Mrs	Caroline	Parnell	Company Secretary/Executive Assistant to CE
Mr	Chris	Newton	Director of Finance
Mrs	Pauline	Singleton	Non-executive Director
Mrs	Susan	Watson	Director of Operational Services
Mr	Stuart	Fallowfield	Audit North

Henrietta Wallace welcomed Mr Chris Harrison, Director of Human Resources to the meeting.

2 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 8 February 2012 were accepted as a correct record.

3 MATTERS ARISING/ACTIONS

May 2011/2 Complaints Referred to the Ombudsman – Report deferred until April 2012.

4 GOVERNANCE REPORTING

4.1 INFORMATION GOVERNANCE TOOLKIT – FINAL SUBMISSION

Summary: Nicky Huntley informed the committee on progress prior to submission of the toolkit at the end of March 2012. Since the last update in October a significant amount of work has been undertaken to improve information governance processes.

Discussion: In October 2011 the progress report highlighted a number of standards below the level 2 standard with a progress score submitted as 64%. Following progress made between October and March a score of 75% is predicted which shows a considerable improvement. Assurance is provided on the basis that level 2 is achieved by 31 March

Two issues were identified as currently scoring below a level 2. The first is requirement 9-112 in which 95% of staff are to have undertaken information governance training annually. If 95% of training is achieved the score could go up to level 3 but if not then the score could be around level 1. Currently reporting 61%. The general feeling is that this is being affected by the effort last year to ensure all staff undertook the training before the year end and many are now due for refresher training in February and March. Figures were not available for NYYPCT at the time of the report so this may impact on the above percentage.

The second is requirement 9-324 regarding the pseudonymisation of person identifiable data. Development of a Management Information System is on hold and the Information Governance team is working with the Head of Information to review the process design. An action plan is in place and the Standard Operating Procedure for Secondary Use of Identifiable Data is out for consultation. A Safe Haven is in place within the Information Department. The score for this requirement is dependent on a number of other standards also scoring level 2 (including 9-112) and therefore a lower score for another related standard could adversely affect the score.

It is currently a requirement of the commissioning contract that the 2 GP practices comply and submit a GP IG toolkit. The Information Governance Department is working with the business manager from the Marske Medical Centre and the Resolution Centre to ensure the appropriate requirements are reviewed and comply. Each practice is currently self-assessed at level 2 compliance. The pseudonymisation standard does not apply to GP practices.

Fran Toller reported concerns from staff who have had difficulty accessing the electronic training module as well as the speed of the system. Nicky Huntley confirmed that the team is aware that staff are struggling. It was suggested that IG could provide a presentation similar to the format last year with self declaration as a solution and this was discussed. Nicky Huntley agreed to consider providing this again. Tricia Hart felt that it was important to ensure that training was undertaken and to avoid a tick box exercise. Nicky Huntley commented that some divisions/departments had identified their own IG trainer which was proving helpful to their divisions/departments as well as alleviating some of the training pressures faced by the IG department. Nicky Huntley confirmed that the training options/access would need to be reviewed for 2012/13.

Agreed:
IGC was assured that the Trust's scoring against the toolkit is improving, and noted the 2 areas which as yet were non-compliant and the actions being taken to address these.

Actions:	**By:**	**Deadline:**
Note the progress against the IG Toolkit for 2011/12	Mrs N Huntley	

4.2 ACTION PLAN TO ADDRESS THE INTERNAL AUDIT RECOMMENDATIONS ARISING FROM THE REVIEW OF CLINICAL AUDIT

Summary: Ruth James updated following the review of Clinical Audit and presented the action plan to address the Internal Audit recommendations. A limited assurance report was issued in November 2011 and a number of areas had been identified where processes could be

strengthened to ensure resources are used effectively and audit findings are followed up.

Discussion:

Recommendation 2.2 – the requirement for the central team to oversee all clinical audit activity in divisions and directorates is not feasible. It needs to be accepted that a degree of responsibility lies with the division to review and escalate results as required. Need to include in the policy that all directorate priority clinical audits should have a process to review audit, which includes senior medical staff, to ensure that any issues which present a significant risk to patient safety are escalated to the Clinical Standards Sub Group.

Recommendations 23 and 28 – recommendation relating to audits which are started but not completed. The majority relate to audits commenced by junior doctors as part of their training but moving onto other areas before completion. As a teaching hospital it was felt important to continue to support audits undertaken by junior doctors as part of training. Work has been undertaken to try and address this issue and every audit has a clinical lead who should be notified if audits are to be abandoned. Very difficult for central team to monitor and the suggestion is that the Clinical Audit Steering Group should be notified of audits which are not progressing and review and advise whether any would pose a significant risk if not completed and escalate any concerns to Clinical Standards Sub Group.

There was brief discussion around the value of audits which are started by junior doctors and then abandoned. Rob Wilson felt that they are worthwhile as doctors are gaining training through the process.

Recommendation 2.5, 2.6 and 2.7 – a recommendation to follow up actions resulting from audits. Each audit generates an action report indicating areas where standards are not met for the team to identify actions required. Due to the volume it is not feasible for the central team to monitor that all audits are complete and chase up action plans. A risk matrix will be developed which will be tested in March and April and then adopted if satisfactory. Divisions are to develop audit plans which will be risk rated to enable high risks to be identified. Risk rating system could be used to flag up risks to Clinical Standards Sub Group.

The question of divisions providing feedback throughout the year was raised and this was discussed. Ruth James explained that divisions are not asked to produce an annual report and feels it important to maintain a level of ownership at divisional level. She further explained that NICE audits are monitored through the NICE database and national audits such as falls and stroke, which are part of directorate plans, may come through Clinical Standards Sub Group as presentations. In response to Tricia Hart's question about comparison with other organisations, Ruth James stated that she felt that the trust is comparable and that most other organisations also have issues with junior doctors completing audits. Henrietta Wallace updated that junior doctors are expected to demonstrate in their portfolios that audits have been undertaken as part of ongoing development and training.

Ruth James agreed to bring the Trust-wide Clinical Audit Plan for 12-13 to IGC and this will use a risk rating approach.

Agreed: The Committee supported the actions proposed to address the recommendations in the Internal Audit Review.

Actions:	**By:**	**Deadline:**
Trust Wide Audit Plan to IGC	Ms R James	May 2012

4.3 ANNUAL REVIEW OF NICE GUIDANCE UPDATE

Summary: Ruth James updated on the actions taken following the review of NICE guidance and highlighted the key issues. She explained that the role of Nice Action Group (NAG) is to receive guidance and identify a clinical lead to provide information about compliance. The report shows that the Trust is compliant with guidance issued up to March 2011, some outstanding audits are being followed up. A further report is planned in a couple of months

around guidance which has come into the organisation since March 2011. Ruth James highlighted the difficulty for clinical teams of auditing all guidance when quality standards are increasing and felt that prioritisation was necessary by use of risk rating as described in the proposed actions relating to clinical audit planning.

Rob Wilson updated on TA044 metal on metal hip replacement and explained that the technique was introduced in 2004 with approximately 20 carried out here in 2004 but none since. There are some issues with the surrounding hospitals which are under debate. Rob Wilson reassured that this is not an issue for this trust as this procedure has not been carried out here since 2004, patients are being monitored and robust surveillance procedures are in place.. Update will go through CSSG.

Agreed: The committee received assurance from the report.

Actions:	**By:**	**Deadline:**
NICE compliance annual report	Ms R James	March 2013

5 CARE QUALITY COMMISSION

5.1 CQC FEEDBACK MHA

Summary: Bev Walker gave a verbal update following the site visit. In line with the Mental Health Act the commissioner requires a site visit between 12 and 18 months to ensure systems are robust. Case notes are examined for people detained under the Mental Health Act. Previous inspections have raised some concerns and action plans had been provided. Verbal feedback following the visit identified that there were no significant concerns. They were pleased to see that we had a robust Service Line Agreement to provide administrative elements for patients detained under the Mental Health Act. It is important to ensure that staff know where documents should be filed. Training with Health and Safety Team who will go out and receive papers on behalf of the trust for patients detained under the Mental Health Act. Specialist Nurse for Safeguarding Adults has to ensure paperwork is forwarded correctly. . When available the formal report is to be presented to IGC.

Agreed: The committee agreed that the feedback was generally very positive. It was agreed to receive the formal report once available.

Actions:	**By:**	**Deadline:**
IGC to receive formal report	Mrs B Walker	April / May 2012 when available

6 QUALITY OF CARE AND PATIENT SAFETY

6.1 OUTCOME OF COMPLAINTS PROCESS

Summary: Rachel Jamieson-Gaffney updated on results from the pilot of the revised complaints handling process. Evaluation of data across the performance indicators was carried out in consultation with divisional managers, complaints leads and corporate members.

Discussion: Prior to the changes the Patient Relations Department (PRD) were spending large amounts of time chasing responses and skills within the team were being under used. Initial improvement was not sustained as the pilot progressed. Comparison between the old and new systems and from general feedback from divisional managers and PRD revealed a considerable increase in workload without additional resources. Comparison of data was fair as numbers were the same.

Feedback and evaluation suggested:

- Divisions felt that they were losing ownership.
- They were no longer drafting responses and wanted it back in the new process.
- Some issues identified were slightly different from original complaint letter.
- PRD were unable to answer some of the questions which could have been answered by divisional contact.
- The number of reopened complaints remained unchanged.

- That it was best for those with knowledge to have discussion with complainant.
- Timescales for responses increased from an average of 41 days to 49 days.

There were a number of negative aspects but also some positive.

After consultation the recommendation was to agree some compromises building on the positive aspects and 10 recommendations were agreed including that:

- the majority of the workload be taken back by the divisions and they will have initial contact with complainant and draft the response.
- the senior management team in the divisions will take more responsibility and will have ownership but PRD will need assurance that the divisional management team has seen the draft response prior to submission to PRD.
- a single point of contact within the division is required.
- divisions will be much more performance managed in relation to KPI and this will be part of the monthly performance reviews which will help identify whether additional support is required.
- a flow chart has been reviewed with divisional managers and leads.

Kath Elliott felt that the time allocated for divisional process was too short and questioned whether the time allocated to the PRD process could be shortened to allow more time for the division. Following discussion Rachel Jamieson-Gaffney agreed that providing the standard of the response improves more time could be allocated to divisions.

Agreed: Update provided clear analysis of the trial. Agreed with Rachel Jamieson-Gaffney that PRD give more days to the division. Further feedback received through annual report.

Actions:	**By:**	**Deadline:**
Annual Report to IGC	Mrs R Jamieson Gaffney	May 2013

6.2 QUALITY ACCOUNT 2011/12 PROGRESS REPORT

Summary: Ruth James updated on progress with the Quality Account 2011-12 and summarised the process for establishing the priorities for the next financial year. Feedback from staff, patients and external stakeholders has been used to establish priorities. Response rates from staff were good. It was agreed that there were three clear priorities:

- Patient Safety – focusing in on discharge and healthcare acquired infection.
- Clinical Effectiveness – focusing on right care, right place and time, and nutrition.
- Patient Experience – improving communication.

Leads now need to be identified for each of the initiatives and mechanisms put in place to measure improvements which will be included in the report. Regarding the current year's priorities, progress has been made across each area. Guidance from the DH includes a requirement to include reporting on additional indicators which is recommended for inclusion this year and will be mandated for next year.

Work is progressing with the development of the Quality Account report for 2011/12. Ruth James outlined the schedule for presentation of papers to the various committees and informed that the Council of Governors was briefed on 14 March on the selection of quality account priorities. The Council of Governors is also required to identify a local indicator for external audit to review as part of their limited assurance report on the quality account; the Council of Governors chose falls. Data is being collated but some of the final year data will not be available until 20 April. Submission of the final report to Monitor will be due on 31 May 2012.

Regarding priorities for next year, Ruth James was asked whether measures to improve the number of outliers in the Trust could be included. Ruth James informed that she has asked Gill Collinson for feedback about progress to improve patient flow and will check whether it will be appropriate.

In response to questions around complaints with a communication element, Henrietta Wallace raised the question about progress with patients receiving copies of letters. Rob Wilson explained that there have been a number of attempts to address this and that colleagues have concerns about the considerable cost implications and feels that this is not generally an issue in complaints. Although some divisions have taken this forward this allowance had already been made in their budgets

Actions:	**By:**	**Deadline:**
Present draft Quality Account	Ms R James	April 2012

6.3 NOTES OF THE CLINICAL STANDARDS SUB GROUP

Summary: Rob Wilson highlighted the key issues from the meeting held on 21 February 2012.

Holmium laser enucleation of prostate (HOLEP) – an update was received on results achieved following the introduction of the procedure to treat prostate problems. Majority of work is being carried out at FHN. Good results are reported and this is now taking over from traditional surgery. Training some people at JCUH to carry out surgery has commenced.

Pre-visit questionnaire and consent form – living kidney donation – related donation was discussed. Dr Wroe reported positive results this year with increase in transplantation of living related donors. Involves a lot of pre-op work-up being carried out.

Dissemination of local guidelines – Path.Finder has now been switched off. Some teething problems but progressing.

Rob Wilson reported that the improvement in medics attending the sub-group has continued.

7 RISK AND ASSURANCE

7.1 REVIEW OF THE BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

Summary: Ruth James updated on the Board Assurance Framework and the Corporate Risk Register and highlighted the key issues.

Board Assurance Framework - updated to reflect current position but no significant changes. Review required with CDs. The BAF will be further revised once the Trust's strategic objectives for the coming year have been agreed.

Corporate Risk Register – no new risks and none have increased.

Agreed: The committee received the reports and agreed that no risks required 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 6 March.

Divisional presentations were received from Neurosciences and Women and Children who reported on the increase in incidents rated moderate to severe which was identified in the last governance report. Fran Toller clarified that investigation revealed that 3 main factors contributed. All incidents were obstetric related.

- There has been a change to the reporting mechanism for maternal blood loss, with the result that more "moderate" graded incidents are being reported (40 incidents reported which would not have previously been recorded as moderate).
- Delivery rates have been higher this year and standards are set by CNST on what is reported;
- Generally encouraged staff to report more incidents as part of CNST assessment but no

themes have emerged.

The group were assured that no further action was required.

Point of Care Testing (POCT) – Further information was received. Work strategy to address testing and standards will be a CPA, NHSLA and MHRA accreditation measure. Currently we would not meet the criteria. Some issues will need to be resolved but some progress has been made. Further update to be given to Risk and Assurance Sub Group in 6 months.

Training Application for Level 1 Mental Capacity Act (2005) Presentation of Liberty Standards – was discussed. It was agreed that training should be mandatory and should go on to the Training Needs Analysis but will have to go through the approval process. Bev Walker will present the proposal to FMG and outline the implications for staff.

G62 Safeguarding Adults Policy – an update was received highlighting some changes to the policy.

OFSTED/CQC – Children Safeguarding Board Action Plan – update received. Action plan in place and expect to be able to report all areas as green.

Complaints and incidents were discussed and there were no themes. Discharge incidents were also discussed following an increase previously identified. Significant number in Division of Medicine but this relates to the type of patients. Self discharge, absconding predominantly in A&E and AAU. Incident information suggested issues were around lack of understanding of the roles and practices of professionals and lack of attention to detail but some of this can be attributable to pressures on staff.

Discussion: Henrietta Wallace questioned whether Point of Care Testing should be added to the risk register but Ruth James felt that as it was already on the pathology risk register it was still seen as a divisional level risk and the issue is around divisions knowing what is required in terms of testing and calibration. 2 people have recently been appointed to address POCT

8 ORGANISATIONAL CAPABILITY

8.1 MEASURING AND MONITORING DATA QUALITY

Summary: Gillian Brown and Alison Davis from Information provided an update on the trust's data quality in comparison to other acute providers for clinical and non-clinical datasets and summarised the key issues. The quality and accuracy of clinical and non-clinical coding, information governance and the programme of work has been assessed.

Discussion: Coding is audited on an annual basis by the Audit Commission as part of the Payment by Results (PbR) Data Quality Assurance Framework. Scores for 2011/12 are within the bracket of the upper national standards and there has been ongoing improvement in all four areas: primary diagnosis, secondary diagnosis, primary procedure and secondary procedure. In addition to the external audit that is undertaken an internal specialty audit programme highlights any coding problems which impact on the quality of coding. Again significant improvements have been made in 2011-2012. In response to questioning around the small number of standards shown to be below the national standard across the 4 categories and 19 specialties, Gillian Brown assured that significant data quality is in place and shows an improvement compared to last year despite 16% reduction in workforce costs.

Non-clinical data quality compares favourably with our peers (CHKS) with only 2 small areas below peer (in GP practice where it was reduced slightly and HRG4). The problems have been identified and hope that data will show work carried out to improve this.

In terms of assurance, a validation process is in place and is reported on a monthly basis. It is planned that this should become a weekly process with more data items. The Data Quality

Team is responsible for 9 of the standards in the Information Governance toolkit and achieved level 2 on all standards related to acute services. There will be an impact on resources in moving to weekly and Gillian Brown explained that increasing to weekly depends on whether posts for the 2 vacancies can be filled particularly as levels of queries are increasing.

Data will be reviewed relating to community services. The team are working with staff on data recording for the in-patient system which is smaller and more easily managed and is nearing completion. Next year it is planned to move onto the out-patient areas which will be more challenging as it covers a large area, significant number of services and data presented in various forms.

Agreed: The committee received assurance that the quality of clinical and non clinical coding is improving.

8.2 NOTES OF THE ORGANISATIONAL CAPABILITY SUB GROUP

Summary: Chris Harrison highlighted the key issues from the meeting held on 26 January 2012.

Updates were received on appraisal and on mandatory training and the changes which have been made in line with NHSLA requirements.

Workforce risks were reviewed and key issues highlighted. There was some discussion around the effectiveness of the scoring in relation to the workforce risk register and further work is in progress.

Data was provided at the end of January as part of the Equality Monitoring Report.

Discussion: Henrietta Wallace explained that IGC received a report last month on workforce risks. Lisa Tempest updated that there was discussion around community services risks in the meeting and community services information will be included in the risk registers, possibly using DATIX to identify workforce risks.

Actions:	**By:**	**Deadline:**
Discuss with Kay Davies DATIX and community services	Ms R James	May 2012

ITEMS FOR INFORMATION

9. ANY OTHER BUSINESS

Lt Col Gary Kenward updated that Col Ian Simpson will be taking over from Col Solly at MDH. He also informed the committee that an assessment will be taking place on 27/28 March in line with the Common Assurance Framework which is a military governance framework. The Trust will be notified of any issues identified which are relevant to the organization.

10. CONNECTIVITY - none

11 DATE AND TIME OF NEXT MEETING

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

The meeting closed at 4.55 pm