South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	27 November 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 10 October 2012

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

Summary:	Review of compliance with framework for quarterly declaration for Monitor's Governance Framework – assurance received that compliance can be declared for Quarter 2. Update on the use of the Quality Impact Assessment from Monitor's Governance Framework – the committee considered the proposals for changes to the template used to assess the impact on quality of P&E projects, and will receive feedback following completion of the consultation process. Joint CQC/Ofsted report – overall findings relating to keeping children safe were good. Action plan in response to PHSO recommendations in relation to upheld complaint – the key issues were highlighted and assurance was received that necessary actions had been taken. Update report on cancer peer review outcome – no immediate risks or concerns were identified. External peer review for Acute Oncology Service, Brain and CNS is scheduled for November. Review of Board Assurance Framework & Corporate Risk Register – no new risks require escalation. Updates were received and progress noted with the implementation of the Transforming the Care we Deliver programme and the appraisal and mandatory training processes. The notes from the Clinical Standards Sub-Group and Risk and Assurance Sub-Group and the Organisational Capability Sub Group 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 10 OCTOBER 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
Dr	George	Ewart	Non-executive Director
Mr	Chris	Harrison	Director of HR
Mrs	Nicky	Huntley	Information Governance Manager
Mrs	Linda	Irons	Chief of Clinical Support Services
Mrs	Caroline	Parnell	Company Secretary/Executive Assistant to CE
Ms	Ruth	James	Deputy Director of Healthcare Governance and Quality
Mrs	Pauline	Singleton	Non-executive Director
Mrs	Yasmin	Scott	Divisional Manager Representative

IN ATTENDANCE

Mrs	Joanne	Dewar	Director of Information – for item 6.1
Mr	Brian	Simpson	Financial Services Manager for Chris Newton
Mrs	Dawn	Bowyer	Acute Medicine for item 6.3
Mrs	Val	Merrick	Secretariat

1 APOLOGIES FOR ABSENCE

Mrs	Kath	Elliott	Senior Nurse for Surgery
Mrs	Tricia	Hart	Deputy CEO/Director of Nursing/Patient Safety
Lt Col	Gary	Kenward	MDHU Representative
Mr	Chris	Newton	Director of Finance
Mrs	Bev	Walker	Assistant Director of Nursing/Patient Safety
Mrs	Susan	Watson	Director of Operational Services
Ms	Lisa	Tempest	Community Services Representative

2 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 12 September were accepted as a correct record.

3 MATTERS ARISING/ACTIONS

Sept 2012 4.1 Trust Wide Quarterly and Quality Report Qtr 1 2012/13 – Executive summary went to Board and Qtr 2 is to go to the next Council of Governors meeting.

July 2012/4 Notes of the Clinical Standards Sub Group – Professor Wilson updated on advice received on VTE prophylaxis from Sir Michael Rawlins, Chair of NICE during the recent visit to Teesside and reported that orthopaedic surgeons are now following NICE guidance.

Sept 2012/3 Terms of Reference for Organisational Capability Sub Group – Henrietta Wallace clarified that the reporting structure stated that the amended Terms of Reference should be approved by Board.

4 GOVERNANCE REPORTING

4.1 REVIEW OF COMPLIANCE WITH FRAMEWORK FOR QUARTERLY DECLARATION FOR MONITOR'S GOVERNANCE FRAMEWORK

Summary: Ruth James updated on the trust position with compliance with the requirements of Monitor's Governance Framework and progress since the last quarter.

Discussion: Previous issue of outstanding work on reporting clinical audit and processes for compiling quality reports has been addressed and is now compliant. There is now a guideline for analysis and improvement which is available on the intranet. A new process for reporting clinical audit has been agreed and will be reported through Clinical Standards Sub Group in greater detail and escalation though IGC to Board.

There is still further work to do to embed the use of quality impact assessments within the organisation (see agenda item 4.2).

The Committee agreed that the outstanding work related to processes and was not material to the declaration of compliance.

Compliance can be declared for Quarter 2

Agreed: The committee received assurance that compliance can be declared for Quarter 2.

4.2 UPDATE ON THE USE OF QUALITY IMPACT ASSESSMENT FROM MONITOR'S GOVERNANCE FRAMEWORK

Summary: Ruth James updated on the Quality Impact Assessment process for trust projects. She explained that the trust needs to demonstrate that a quality impact assessment has been undertaken when approving cost improvement and productivity projects.

Discussion: Monitor require trusts to declare that the CIP has been quality impact assessed and a named senior person has signed it off. The operating framework says that organisations need to show that this is happening to ensure that cost improvement measures do not impact adversely on quality of care. Ruth James stated that currently the Project Assurance Office template contains a worksheet to identify and monitor quality impacts which project leads should populate and use. In practice the template is not being used as intended. Feedback from divisions and project leads identified the following:

- concerns that the data requested duplicates information given in the quarterly governance report
- issues with a single spreadsheet as a number of P&E projects may be monitored as a program of work through a single template making it difficult to assign quality impacts to individual projects.
- some projects don't impact directly on patient care
- concern about duplication of monitoring of corporate projects.

The National Quality Board has just published guidance which includes a template used by Birmingham Children's Hospital which takes a quality risk scoring approach. This was included as an appendix to the report together with a simplified local template. The Committee discussed the pros and cons of both templates and the potential to quality impact assess a program of work instead of individual projects. Consultation is to take place with Divisional Managers following which a single approach would be trialed and it is hoped to implement the agreed approach in time for the next financial year.

The next step is to discuss with Divisional Managers in October and agree the best way forward with a report back to IGC next year. Needs to be included in the annual planning process.

Agreed: The committee considered the proposals. Feedback to IGC next year.

5 CARE QUALITY COMMISSION

5.1 JOINT CQC/OFSTED REPORT

Summary: Ruth James reported on the findings following the CQC/Ofsted inspection of Safeguarding and Looked after Children Services in Redcar and Cleveland. The inspection was part of a planned cycle of inspections between 21 May and 1 June 2012. Overall the findings for each criteria relating to keeping children safe were good. Partnership working was good and the overall services for looked after children was also found to be good. A small number of areas for improvement were identified. An action plan will be developed to address the recommendations and progress will be reported in 6 months.

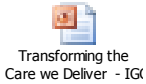
Agreed: The committee accepted the report.

Actions:	**By:**	**Deadline:**
Report back on actions to IGC in 6 months	Bev Walker	April 2013

6 QUALITY OF CARE AND PATIENT SAFETY

6.1 TRANSFORMING THE CARE WE DELIVER

Summary: Joanne Dewar gave a presentation on Transforming the Care We Deliver (attached). She explained that the vision is to provide the best healthcare experience through the use of technology that is accessible, easy to use, available 24 hours a day and always correct. A significant amount of work is being undertaken to improve the infrastructure.


Transforming the Care we Deliver - IG(

There are 3 work streams

- Electronic Patient Records
- Electronic Document and Records Management
- ICT Infrastructure.

The Programme Board structure is clinically led and includes Richard Wight as the Senior Responsible Owner, Tricia Hart as EPR Project Lead and Vince Connolly as EDRM Project Lead. Chris Newton as Director of Finance provides financial advice. A Clinical Evaluation Team has been agreed, representatives from MDT teams have been recruited, clinical scenarios have been written and there have been presentations from bidders. Working on wider engagement in the organisation through a number of initiatives including meetings with approximately 100 staff involved in the programme and also discussion at corporate meetings.

Progress to date:

- 26 bidders expressed an interest with 7 shortlisted.
- Invitation for bidders to participate in dialogue (March 2012). Clinical and Non-clinical staff evaluated responses and Capita and CSC progressed to next stage.
- Dialogue process underway leading to issue of ITPD2 at the end of October.
- Hope to award contracts towards mid-year 2013.

Joanne Dewar outlined what the organisation requires from a strategic partner. Taking the workforce through the changes will be a challenge and requires someone who can help with making systems as simple as possible.

Discussion: In response to questions on timescales Joanne Dewar explained that the first priority is clinical systems. There needs to be significant investment in infrastructure, to deploy mobile devices and staff need to be familiar with them. Rob Wilson felt that electronic prescribing would be a massive step forwards in reducing issues around prescribing and medicines reconciliation and asked about the timescales. Joanne Dewar responded that

timescale for the first phase would depend on resources but her estimate would be about 2 years.

Agreed:
The Committee thanked Ms Dewar for her presentation and noted progress with the programme.

6.2 NOTES FROM THE CLINICAL STANDARDS SUB GROUP

Summary: Rob Wilson highlighted the key issues from the meeting held on 16 September 2012.

NCEPOD Cardiac Arrest Study – the report was presented. Comments on DNAR were included. A regional piece of work "Deciding Right" has been rolled out and there is now a separate group dealing with this which is chaired by Richard Rigby. Although the report shows there are areas for improvement it was noted that only a few of the 472 patients studied were ours and most of the comments related to national issues. There is still work to be done on EWS (Early Warning Scores) and this and a business case is being developed.

Regional Diabetes Chart – this initiative relates to standardizing diabetes charts across the region. When trainees move around the region as part of their training the charts will look the same.

National Audit of Inflammatory Bowel Disease – Helen Dallal presented on the outcome. Issues raised are being actively addressed and significant progress is being made.

There have been a number of discussions around mortality reporting and there is to be a separate group which will report into Clinical Standards Sub Group to ensure there are appropriate levels of discussion throughout the organisation and escalation to the Board.

6.3 ACTION PLAN IN RESPONSE TO PHSO RECOMMENDATIONS IN RELATION TO UPHELD COMPLAINT

Summary: Dawn Bowyer, Directorate Manager, Acute Medicine, updated on actions taken following a complaint upheld by Parliamentary Health Services Ombudsman (PHSO). The complaint has now been closed.

Discussion: Dawn Bowyer highlighted the main issues raised in the complaint and the subsequent involvement of the PHSO. The complaint concerned clinical care, lack of communication with the family and medicines reconciliation. The complainant was unhappy with the response received following the trust complaint investigation and contacted the PHSO who upheld the complaint. The PHSO concluded that communication was at fault, treatment following diagnosis was inappropriate and medicines reconciliation was not accurate

Actions taken:

- Action plan put in place to address family's concerns include clinical care issues and medicines.
- Attitude and decision-making has been addressed with medical staff.
- Discussion around communication and skills has been discussed with nursing staff.
- A meeting has taken place with the Medical Director and Acting Director of Nursing to review the case.
- PHSO has received action plan and communicated with the family.
- A letter of apology has been sent to the family and copied to the CQC, local commissioners and Monitor.

Addressing some of the issues raised, Rob Wilson stated that in his view the introduction of electronic prescribing would improve medicines reconciliation. Communication has been raised with Chiefs and consultants and FY doctors at induction. He also felt that independent review was always beneficial in such cases. The question of whether nursing staff were aware of

prescribing and why problems were not flagged up earlier was raised and this was briefly discussed.

Agreed: The committee was assured that necessary actions had been taken.

6.4 UPDATE REPORT ON CANCER PEER REVIEW OUTCOME

Summary: Louise Shutt, Cancer Services Manager summarised the key findings from the cancer peer review internal validation reports and self assessment summaries.

Discussion: The process has now been completed. Among the various cancer MDTs compliance ranges from 67% to 90.7%. Compliance above 50% is considered to be satisfactory. Concerns raised include:

- Attendance at National Advanced Communication Skills Training. This is related to external pressure for places.
- Teenage and Young Adult Specific measures for MDTs - not an outlier. Includes measures incorporated into MDTs. Most areas compliant but some slippage across the board.
- Specialist palliative care core membership.

No immediate risks or serious concerns were identified. Action plans will be linked into the planning cycle and any concerns addressed with each division. There is an external peer review visit for Acute Oncology Service, Brain and CNS scheduled for November. No concerns have been identified.

Agreed:
Outcome of the external peer review visit in November to be reported to IGC, on an exception basis. IGC was assured of progress, and Louise Shutt and her team were thanked for the positive report.

7 RISK AND ASSURANCE

7.1 REVIEW OF BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

Summary: Ruth James presented the Corporate Risk Register and the Board Assurance Framework and highlighted the key issues and these were discussed.

Corporate Risk Register
The committee sought the view of Joanne Dewar on whether the emerging risk around failing desk top computer hardware should be escalated as a corporate risk. Joanne Dewar explained the current issues and stated that in her view it should remain on the divisional risk register.

Board Assurance Framework - All risks have been updated. The risk score for two risks relating to the financial position in North Yorkshire has increased.

Agreed: No new risks require escalation.

7.2 NOTES FROM THE RISK AND ASSURANCE SUB GROUP

Summary: Ruth James highlighted the main issues from the meeting held on 2 October 2012.

There were 3 divisional presentations from Pathology, Radiology and Operational Services around their risks and how they are being managed. Pathology have been asked to review longstanding risks to see if any are at a level that can be tolerated and removed from the register. Radiology has a good system for maintaining the register and the small number of risks is being managed.

Bev Walker updated on sharps incidents which will be RIDDOR reportable from next year. Bev Walker asked for this to go on to the HCG Risk Register initially.

IT was discussed including desktop, virtualization and backup expansion. We are aware of the risks and plans to address them are in place.

Nicky Huntley updated on progress with the integration of information risk management process.

The group considered an audit of trust policies which forms part of the NHSLA monitoring. A number of policies require updating and work continues to encourage colleagues to address this.

There was a briefing on the divisional plans for business continuity.

Patients Relations – increase in trend of complaints involving clinical/medical care. Risk and Assurance Sub Group to receive further analysis on this category of complaint.

SUI report was received and discussed. Pressure ulcer incidents remain a concern. A report to IGC is scheduled for November.

8 ORGANISATIONAL CAPABILITY

8.1 UPDATE ON RESTRUCTURE OF HEALTHCARE GOVERNANCE DIRECTORATE

Summary: Ruth James updated on the restructure of the Healthcare Governance Directorate. The restructure focused on improving efficiency, reducing duplication and aligning interdependent activities. She highlighted the changes being made to posts and responsibilities. The consultation period has closed and recruitment processes are underway.

8.2a UPDATE ON IMPLEMENTATION OF APPRAISAL PROCESSES AND PROGRESS AGAINST TARGETS

Summary: Chris Harrison updated on the implementation of the revised processes and progress against targets. All appraisal records are now recorded on the Electronic Staff Record System (ESR).

Discussion: Appraisal rates are improving which is encouraging but more work is needed to reach the target of a minimum 80% compliance. In the last 12 months appraisal rates have risen from 57.02% to 69.51% in August. The initiative is being driven through performance reviews and divisions have been asked to achieve 80% in most areas by Qtr 2. Since the report, work has progressed on revising the policy and ensuring accuracy of data held on ESR. Work is being done with individual managers within divisions to help with training and understanding how data is recorded, helping them to focus on areas of poor performance. A pilot study in Women and Children showed improvement and will now be rolled out to other areas. The Trust is currently using KSF system and some staff, particularly nursing, prefer that approach. Other organisations are using something shorter which might make it easier for staff and this is being investigated.

Pauline Singleton questioned whether we were moving away from the knowledge and skills framework as she felt it important for nursing staff to demonstrate what they have done. Chris Harrison stated that it is important to consider how we can help people conduct an appropriate robust appraisal and would like to consider using a shorter version, as appraisal is about how staff are performing against the standards they should be delivering

Henrietta Wallace asked Yasmin Scott for her views on barriers to appraisal in her division. In response Yasmin felt that short term sickness and lack of time had an impact and resulted in SDRs not being done. Acute Medicine are trialing different methods to try to address this including doing SDRs in particular months and also group SDR which seems to have worked well.

Agreed: The committee accepted the report, and received assurance that progress was being made towards achieving higher SDR rates across the organisation.

8.2b UPDATE ON MANDATORY TRAINING PROCESSES AND PROGRESS AGAINST TARGETS

Summary: Chris Harrison updated on the implementation of mandatory training process and progress against targets. Mandatory training levels continue to be monitored against the 80% compliance target.

Discussion: Chris Harrison explained that the influx of additional elements of mandatory and the additional staff employed in community services has impacted on compliance. Compliance is now around 45% but prior to the addition of new requirements was about 62%. The Mandatory Training Policy is in place for NHSLA. Work continues to try to establish means of encouraging staff to undertake training, and exploring e-learning packages which may make it easier for people to access training. Managers have been asked to look at whether the training listed for staff is needed and to looking at what can be delivered within the timescales and resources.

Agreed: The committee received assurance from the report and acknowledged the challenges in achieving compliance.

8.3 NOTES FROM THE ORGANISATIONAL CAPABILITY SUB GROUP

Summary: Chris Harrison highlighted the key issues from the meeting held on 20 September 2012.

Organisational Capability Sub-Group Revised Terms of Reference – discussion is continuing about the sub-group's function and position in the organisational structure.

Sickness Absence – percentage has increased. Monthly target of 3.9% is a challenge. Issues are being addressed. Policy is progressing through the JNC management structure.

Updates were received on SDRs, CMAT and HR operational activity.

LETB & MPET Bundle – changes happening with LETB authorization process scheduled for April 2013. Chris Harrison advised that he would like to establish what happens internally and where information is brought together from representatives on regional groups.

Flu Campaign – lots of promotion and clinics being held throughout the trust.

Workforce Risks - discussion around integrating workforce risks into the divisional risk register and organisation's risk management process.

Discussion: Chris Harrison updated on his review to streamline the meeting structure within the HR Directorate. The revised Terms of Reference for Organisational Capability Sub-Group need to be agreed by Board. Chris Harrison is concerned about attendance at meetings. The workforce strategy review has commenced.

Agreed: Terms of Reference to be presented to Board in January.

Actions:	**By:**	**Deadline:**
Terms of Reference to go to Board	Mr C Harrison	January 13

ITEMS FOR INFORMATION

9. ANY OTHER BUSINESS

It was agreed that there will be no meeting of IGC in January 2013.

10. CONNECTIVITY

- Revised Terms of Reference for Organisational Capability Sub Group to go to Board

11 DATE AND TIME OF NEXT MEETING

The next meeting will be held on 14 November 2012 at 3 pm in the Board Room, The Murray Building, JCUH

The meeting closed at 5 pm