Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
1st May 2014

TITLE	**The Integrated Governance and Assurance Committee Minutes**
EXECUTIVE SUMMARY	The key matters discussed in the meeting included the: - Quality, Safety and Risk Management Strategy - BAF - Serious Incident Requiring Investigation Report - Compliance in Practice audit – February 2014.
BOARD ASSURANCE (RISK)/ IMPLICATIONS	IGAC meets on a monthly basis and engages in full and frank discussions about issues critical to high quality and safe care. The recently developed QEWS dashboard will now follow a rigorous production, validation and publishing process. This tool acts as a tool for the committee to engage in 'horizon scanning' in a more evidence-based manner, thus ensuring interventions more effectively pre-empt any harms to patients and staff.
LINK TO STRATEGIC OBJECTIVE/BAF	The scope of the Committee includes assurance overall Strategic Objectives but the work of the Committee focuses on SO 1 and SO 2.
STAKEHOLDER/ PATIENT IMPACT AND VIEWS	This is the most senior Trust Board committee that focuses on quality governance and improvement.
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	None identified
The Trust Board is asked to:	Receive the minutes.
Submitted by:	Philip Beesley, Non-Executive Director and Chair of IGAC
Date:	24th April 2014
Decision:	For Receiving

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC) MINUTES
Monday, 25th March 2014
15:00 – 17:00 hrs
Post Grad Education Centre, Room 1

MEMBERS PRESENT:

CHAIR:	Philip Beesley (PB)	Non-Executive Director
	Valerie Bartlett	Deputy Chief Executive
SECETARY:	Heather Caudle (HC)	Deputy Chief Nurse - Associate Director of Quality
	Simon Marshall	Director of Finance and Information
	Louise McKenzie (LM)	Director of Workforce Transformation
	Andrew Liles (AL)	Chief Executive
	Terry Price (TP)	Non-Executive Director
	Suzanne Rankin (SR)	Chief Nurse
	George Roe (GR)	Head of Corporate Affairs
	Carolyn Simons (CS)	Non-Executive Director
APOLOGIES:	David Fluck	Medical Director
	Mick Imrie	Deputy Medical Director – Chief of Patient Safety
IN ATTENDANCE:	George Absi (GA)	Head of Regulation & Accreditation

ITEM

150/ 2014 The apologies were noted.

151/ 2014 The minutes of previous meeting were approved.

152/ 2014 **Matters Arising**

The Committee reviewed all of the actions from the previous meeting.

Outstanding actions **128/2014** and **125/2014** were on the agenda. **137/2014** had been completed. All to be removed from tracker.

101/2013. The Medical Director to update the Committee at the April IGAC meeting.

153/ 2014 **Quality, Safety and Risk Management Strategy (Patient Involvement Driving Improvement)**

The Deputy Chief Nurse – Associate Director of Quality presented the report. It was stated that in year 2 the focus had been on devolving Quality Governance and the re-structure of the Quality Department. The focus for year 3 was on patient involvement driving improvement, i.e. the Trust will use the patient feedback to drive improvement using the Adaptive Change model. The paper outlined the next 3 steps of the strategy:

1) The launch of the Patient Feedback Driving Improvement, its main focus.

2) The Risk Management Culture.

3) Patient Safety Improvement.

The Director of Finance and Information stated that the focus should be on outcome more than process. The Deputy Chief Nurse – Associate Director of Quality will ensure each area has measurable outcomes/target(s). It is important that the outcomes are linked to the Trust's Business plan. The revised paper will be presented to a later IGAC meeting. **HC**

Work will commence on gaining feedback from patients, families and staff regarding the Trust's complaints process. It was also stated that mystery shopper exercises would take place. Use of electronic data capture real time tools will be assessed. One Non-Executive Director stated that legislation should be the minimum standard for the Trust and that there should be a clear distinction between complaints data and other feedback received.
The Committee requested that a benchmarking exercise against other Trust's patient experience/complaints strategy and process takes place. The Deputy Chief Nurse – Associate Director of Quality to complete and reported back to the Committee. **HC**

154/ 2014 **BAF**

The Head of Corporate Affairs presented the report which is an assurance tool that ensures that the Trust Board is adequately informed regarding the risks to achieving the Trust's Strategic Objectives. The BAF is aligned to the four strategic objectives as detailed in the Corporate Business Plan.

The Committee went through and discussed each risk on the BAF. The Committee agreed to close four risks.

- 1.1 - If there is a national publication at an organisational and/or clinician level of outcome data that is unknown, or unverified, to the Trust and is indicative of poor quality of care
- 1.2 – If the Trust provides poor quality care leading to a

regulatory response by the CQC and/or Monitor

- 3.1 – If the Trust workforce was not appropriately aligned to demand and acuity; particularly to meet reductions in WTE, agency usage and pay costs, resulting in overspends against agreed budgets; and

- 4.4 – If the contribution from individual divisions and service lines is less than required to deliver to EBITDA margin for ASPH as a whole. If ASPH cross-subsidises uneconomic service lines with the financial contribution of unrelated service lines.

Additional risks approved, to be added.

- SO 2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless case and poor patient experience; and

- SO 2.3 Failure to put in place Ann Clwyd / Patricia Hart recommendations around complaints leads to poor patient experience with complaints process.

The Director of Finance & Information and Director of Workforce and OD requested that a risk regarding administrative support was added. The Committee agreed.

The Chief Executive requested that Objective 1: Best Outcomes 1.5 and objective 2: Excellent Experience 2.3 be re-worded. **GR**

A NED requested that a report regarding Ann Clwyd and actions in which the Trust is taking is presented to the Trust Board. The Chief Nurse stated that a full report will be presented shortly.

The Chair stated that there was no need to continue to highlight the top 5 risks within the report, but each paper that goes to Trust Board or to Board Committees should cross reference to risks in the BAF on the cover page. This approach will provide a stronger link between the BAF and Board business. **GR**

The report was approved.

155/ 2014 **Development of RTT trajectories**

The Deputy Chief Executive presented the report and gave an update regarding progress to-date. It was stated that the Trust had experienced issues regarding 18 weeks performance in October and November 2013. Performance has improved since then. The Trust have been working with the National Intensive Support team to develop the trajectories. These trajectories are owned by the Division's specialities. The information has been populated with the performance team.

The report highlighted the extensive modelling exercise that had been undertaken. Progress was on track with the backlog being completed for all Divisions by the end of July. It was stated that further modelling would be taking place and any revision to the timetable would be reported to IGAC. The Committee noted the risks associated including funding.

156/ 2014 **Self – Certification**

The Head of Corporate Affairs introduced the report in which a request was made for approval of the report to Trust Board. The Trust is required to submit the Annual Operating Plan to Monitor by 4th April.

The Deputy Chief Executive stated that the 62 day cancer waiting times was a difficult target as it involved the whole pathway and involved of the Cancer Centre at The Royal Surrey. Although the Trust had a good track record of meeting this target there was a significant risk to this looking forward. It was stated that meetings and on-going communication with the Royal Surrey County Hospital NHS Trust had taken place in-order to improve the pathway.

The paper was approved.

157/ 2014 **Serious Incidents requiring Investigation Report (SIRIs)**

The Deputy Chief Nurse – Associate Director of Quality introduced the report. There have been 14 SIRIs since the last report. Of these, six are pressure ulcers and three falls. One of these falls had resulted in a Fractured Neck of Femur (#NOF).

An in-depth discussion took place regarding pressure ulcers led by the Chief Nurse and Deputy Chief Nurse - Associate Director of Quality. A review of these was being undertaken by the Trust's Lead Nurse Tissue Viability in collaboration with an external specialist. The Trust had invested in a Tissue Viability Specialist Nurse during the year. There was belief that some of these pressure ulcers were acquired in the community where training and awareness maybe less than within the acute sector. The Director of Finance and Information enquired whether benchmarking against the community data was collected. The Chief Nurse stated that this is something that they are looking into. The Chief Nurse stated that it was essential that the good practice wards within the Trust shared knowledge across the organisation and that nurses took responsibility and were accountable for their nursing care. The Deputy Chief Nurse – Associate Director of Quality stated that this data would be included in the upcoming nursing revalidation process. The Director of Workforce & OD stated that it was essential that the process was dealt with carefully. A Non-Executive Director (NED) questioned how the Trust was performing against other Trusts in the region. It was stated that the Trust was performing well. Data is collected routinely through Safety Thermometer and other data capturing exercises.
Four cases were approved for closure.

158/ 2014 **QEWS Triangulated Dashboard**

The Deputy Chief Nurse – Associate Director of Quality presented. A detailed discussion took place regarding ward performance and action being taken by lower scoring wards to improve performance. Performance was also triangulated against the January 2014 QEWS dashboard. These wards present frequently to a high-level Scrutiny Committee which includes the Medical Director and Chief Nurse.

A risk summit had taken place regarding Aspen ward and that all key stakeholders had been present. The Chief Nurse stated that it had been a positive meeting whereby recommendations had been put forward including a new senior leadership support team. The Committee will monitor performance progress of the ward. The decline in performance for Medical Assessment Unit (MAU) was associated with the winter pressures and the Chief Nurse was confident that improvements in their score would be seen in the months ahead.

The Director of Finance & Information questioned the friends & family data for A&E and Fielding ward. The Chief Nurse to confirm.

159 /2014 **Patient Experience Monitoring Group Exception Report**

The Deputy Chief Nurse – Associate Director of Quality presented the report. Two risks were reported as per paper.

The Patient Experience Monitoring Group would review actions in the 9th June 2014 meeting.

160/ 2014 **Care Quality Commission – Compliance in Practice audit February 2014**

The Head of Regulation & Accreditation presented the report. The Compliance in Practice audit is a 6 monthly peer review audit which is undertaken in all ward areas. For this audit, a new tool comprising the proposed new CQC standards was used (Are services safe? Effective? Caring? Responsive to people's needs? And Well led?). The tool was developed by the Head of Regulation & Accreditation in collaboration with the Associate Director of Nursing – Trauma and Orthopaedics. A pilot of the tool had been undertaken in two wards.

Overall, the result were positive with 17/30 (60%) being green, 11/30 (36%) of wards achieving yellow. It was stated that for the amber ward, a challenge had been presented by the ward supported by the Division's Associate Director of Nursing, which is being considered by the Auditor of that ward. IGAC would be updated regarding progress at the April meeting. A trend analysis had shown a host of good practice in-regards to wards being safe, effective, responsive to

people's needs and leadership. Moreover direct patient feedback was all very positive except for the question *"are the meals you receive of good quality?"* This had been feedback to the Associate Director of Estates and Facilities. Areas for improvement included raising further awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoL) processes and whistleblowing process. Within some areas documentation needs to be improved.

The Head of Regulation & Accreditation stated that all Ward Managers had received a copy of the auditors completed tools for feeding results back to Ward staff and continuous quality improvement. Staff generally welcomed the audit. The Committee thanked the Auditors for their support in the audit.

A paper regarding triangulated results of the Compliance in Practice, Best Care and QEWs dashboard was also presented and discussed.

A CQC Essential Standards of Quality & Safety report would be presented at the April IGAC meeting. **HC**

161/ 2014 **External Agencies and Inspection Report**

The Deputy Chief Nurse – Associate Director of Quality presented the report. The report updated the Committee on external agencies inspections and visits from the past, present and proposed. The RAG rating plots the progress for maintaining action plans and any recommendations made as a result of reviews.

The Head of Regulation & Accreditation stated that he would liaise with Divisions to ensure the document was updated on a monthly basis.

162 /2014 **Any Other Business**
None.

Date of Next Meeting
Tuesday 15th April 2014, 12:00-14:00 Room 2, Chertsey House, St Peter's Hospital.