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

TRUST BOARD
26th April 2012

TITLE	**IGAC Annual Report**
EXECUTIVE SUMMARY	The report identifies key achievements of IGAC for the period February 2011 to March 2012, and indicates the key areas of work for the twelve month period from April 2012 – March 2013.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The report provides the Board with assurance that IGAC is discharging its duties under the TOR.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not sought
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	None identified
The Trust Board is asked to:	Review the report and request any further actions for the period April 2012 – March 2013
Submitted by:	Philip Beesley, NED and Chair of IGAC
Date:	12th April 2012
Decision:	For Noting

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

ANNUAL REPORT OF THE INTEGRATED GOVERNANCE AND ASSURANCE COMMITTEE
March 2012

Meetings:

Dates of meetings:

- 9th February 2011,
- 6th April 2011,
- 8th June 2011,
- 8th September 2011,
- 7th December 2011
- 21st March 2012

Membership and Attendance

The membership and number of attendances during the period July 2010 to Dec 2010 are as below

1. Associate Director of Health Informatics (6)
2. Chief Executive (4)
3. Chief Nurse (Chair of Patient Safety and Risk Committee) (6)
4. Deputy Chief Executive (4)
5. Clinical Risk Manager / Head of Patient Safety (3)
6. Director of Finance and Information (3)
7. Director of Workforce and Organisational Development (5)
8. Head of Customer Affairs (2 out of 2)
9. Head of Corporate Affairs (5)
10. Head of Quality and Integrated Governance / Acting Head of Quality / Associate Director of Quality (5)
11. Medical Director (Chair of Clinical Governance Committee) (5)
12. Non Executive Director (Chair) (6)
13. Non Executive Director (Chair of Audit Committee) (6)
14. Non Executive Director/Safety Lead – there is no one currently in this role
15. Patients Panel representative (5)
16. Observer: Internal Audit representation (5)

Discharge of Duties and achievements
February 2011 – December 2011

1. Terms of Reference and Membership

The membership structure has been amended to include the newly restructured Quality Department and subcommittee changes. The Terms of reference are amended to reflect this.

2. Control of Risk

Internal audit of risk process

The action plan following the Review of Risk registers Audit Report has been completed and will be reviewed by IGAC in conjunction with the NHS LA inspection recommendations.

Risk register

The Committee has reviewed the risk register at each meeting and received a risk report to assist the review of the risk process.

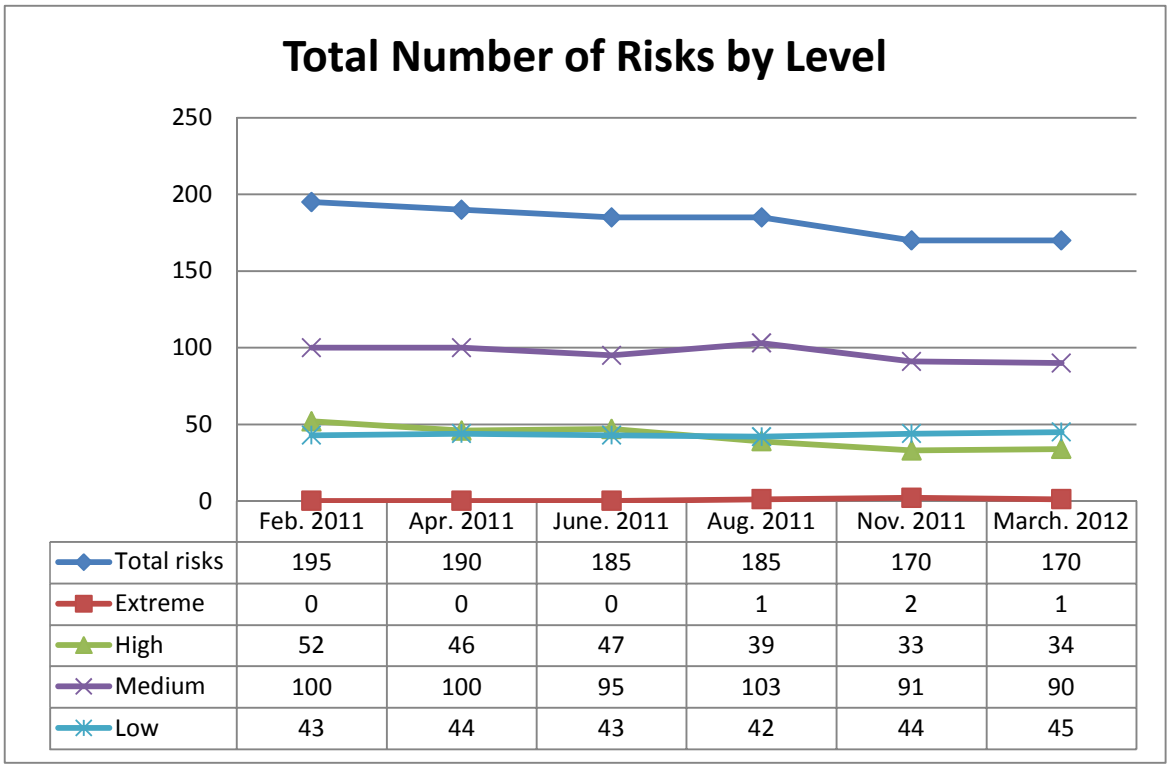
The number of new risks added to the risk register and the number closed during the 14-month reporting period are noted in the table below.

TABLE ONE: Risk Movement between February 2011 to March 2012

	February 2011	April 2011	June 2011	September 2011	December 2011	March 2012
Risks opened since previous meeting	2 High 6 Med 0 Low	6 High 7 Med 1 Low	8 High 2 Med 0 Low	6 High 20 Med 0 Low	8 High 6 Med 0 Low	9 High 4 Med 0 Low
Risks closed since previous meeting	5 High 16 Med 2 Low	4 High 10 Med 5 Low	6 High 4 Med 3 Low	7 High 13 Med 6 Low	6 High 19 Med 6 Low	1 Extreme 4 High 6 Med 2 Low

The Committee has reviewed the movement in the risk register. There has been an emphasis for risk owners to be more robust with their action plans and to assess the risk at each review. Graph one below shows the total number of risks by level.

GRAPH ONE



	Feb. 2011	Apr. 2011	June. 2011	Aug. 2011	Nov. 2011	March. 2012
Total risks	195	190	185	185	170	170
Extreme	0	0	0	1	2	1
High	52	46	47	39	33	34
Medium	100	100	95	103	91	90
Low	43	44	43	42	44	45

Corporate Risk Register (CRR)

The Committee reviews the CRR at each meeting. Areas of particular focus include:

The Risk Register. There was concern throughout the year about the effectiveness of the registers themselves and the risk management processes. Improvements were made to ensure that the Corporate and local risk registers were managed with the appropriate level of rigour to present the assurance to the Board with the appropriate treatment or toleration of risk as required.

The discharge process. This presented risks to patient safety as well as patient experience. Significant Trust-wide improvement programmes such as the Quality Account and the Care Quality Commission compliance action plan included the discharge process as a direct focus of improvement as well as a test of effectiveness. Both programmes were closely monitored by the committee.

The Trust's merger with Epsom Hospital. Epsom Hospital is currently at level one and the Trust currently at level two intending to apply for level three therefore the risk of an automatic drop to level one for the Trust post-merger is significant. The Trust's NHSLA assessor has given some detailed advice which would, if followed, significantly reduce the risk of an automatic drop.

Never Events. There is a need to strengthen the management of Never Events particularly in the context of a revised list from the Department of Health this year.

Delivery of Commissioning for Quality and Innovation (CQUIN) and Enhancing Quality (EQ) targets. One of the very few risks to be increased to Extreme was a description of the potential loss of revenue as a result of failure to secure the improvement and outcome targets agreed to in the contract pertaining to the CQUIN and EQ programmes.

NHS LA

Level two accreditation was awarded to the Trust following an assessment on the 25th and 26th January 2011 and there was a debrief to the Trust on 25th July 2011. The visit for level three will be in January 2014 and the action plan has been agreed. IGAC continued to monitor the actions in preparation for the level three assessment.

Serious Incidents Requiring Investigations

IGAC has received assurance of the process for managing serious incidents requiring investigations (SIRIs). A comprehensive report is reviewed at each meeting and attention is given to adequate action planning and assurance that actions are in place and efective.

The new requirement to report all hospital acquired stage three and stage four Pressure Ulcers by the Department of Health has resulted in an increase in the number of SIRIs reported by the Trust. Consequently, there has been an increase in focus on the Trust's ability to safeguard vulnerable adults from physical harm due to pressure ulcers within its care. The Trust developed a corporate action plan to reduce the number of hospital acquired pressure ulcers and has conducted trend and thematic analyses of pressure ulcer prevalence within the Trust.

SIRIs closed between February 2011 to March 2012 were:

- Patients with Clostridium difficile. Full Root Cause Analysis revealed no cluster was apparent.
- Maternity SIRIs
- Four cases closed:
    1. Death after discharge
    2. Discharge home in pyjamas.
    3. Withdrawal of treatment.
    4. Child death (from 2009)
- Pressure ulcer cases
- Intrapartum Deaths
- Failure to act on test results
- Missed diagnosis

3. Board Assurance Framework

The Committee had received and reviewed the Board Assurance Framework each meeting. In December 2011 the Board together with the Associate Director of Quality participated in an externally facilitated workshop to focus on developing the BAF. Within the workshop there was debate around and exploration of possible options for a new format and management system. A distinction was made between the focus on strategic risks in the BAF as opposed to operational risks, which would be focused on in the Corporate Risk Register. As a result the risks to the delivery of the new Trust strategic objectives were formulated utilising the newly agreed format and this work continues with a view to complete by July 2012.

4. Reporting Committees

The Committee has received reports from Clinical Governance and Safety and Risk Committees at each meeting.

5. Care Quality Commission

The Committee has received assurance reports for the Hygiene Code and Essential Standards of Quality and Safety. A process for providing continual assurance of compliance with the Essential Standards was developed, namely the Compliance in Practice audit tool. A six-monthly audit has been carried out using the tool and its results were triangulated with the standard owners' self-assessment and the Trust's QRP. A Care Quality Commission (CQC) unannounced visit was carried out three months after the first summated self-assessment of the Trust's compliance, which garnered similar findings to the Trust's triangulated self-assessment. The CQC expressed moderate and major concerns over three standards, and compliance actions were issued.

The process of internal self-assessment is being strengthened, particularly its relevance at a divisional level. The compliance assessment software providers, Health Assure is working closely with the Trust on this improvement project.

6. External Review

The external review database lists all external reviews and inspections: e.g. Care Quality Commission, NHS Litigation Authority (NHS LA) inspection, Joint Accreditation Group (JAG) inspection, Ofsted inspection and identifies leads and executive sponsors. The database provides a RAG rating to identify risk to achieving a good outcome from the review or inspection. In addition action plans as a result of review are also added to the database to monitor progress of actions.

Particular areas of focus were:

- The delay of the JAG inspection and the impact of this delay on the quality and safety of our services.
- The CQC visits.

7. Constraints Faced by the Committee

No constraints have been experienced. Committee meetings are well attended with good engagement.

8. Policies which have been Approved and/or Ratified

The following policies have been approved and/or ratified by Clinical Governance Committee or Safety and Risk Committee.

1. Care of Centrally Inserted Vascular Access Devices in Adult Policy
2. Children Safeguarding Policy
3. COSHH Policy
4. Display Screen Equipment Policy
5. First Aid Policy
6. Guidance for Doctors on Post Mortem Examinations

7. Health and Safety Policy and Ratification Form
8. Hospital Cleaning Policy
9. Incident Reporting Policy and Ratification Form
10. Lone Working Policy
11. Management and Reduction of Workplace Stress Policy
12. Management of Healthcare Waste
13. Management of Violence and Aggression Policy
14. Manual Handling Policy
15. Non Clinical Claims (non patient) Policy
16. Point of Care Testing (POCT)
17. Procedure for Conservative Sharp Debridement
18. Respiratory Virus Policy
19. Security Policy
20. Slips, Trips and Falls (non patient) Policy
21. Smoke Free Site Policy
22. Upper Limb Disorder Policy

9. Objectives/Forward Plan April 2012 – March 2013

The Committee will continue to discharge its duties and responsibilities as described in the Terms of reference. A particular focus of the Committee going forward will include the following

- To approve and monitor the effectiveness of the new Quality, Governance and Risk Management Strategy and the Trust's new Committee Structure.

- To receive and scrutinise the new Board Assurance Framework.

- To monitor and proactively manage the Trust's preparation for the NHS Litigation Authority Level 3 Inspection due in January 2014 within the context of the its merger with Epsom Hospital.

- To approve and monitor the improved Corporate and Local risk registers and seek assurance that the training provided is delivering excellent risk management across the organisation.

- To receive and scrutinise the tolerated risk report.

- To seek assurances that the Quality Governance Committee's new way of working is embedded and fulfilling its TOR to a high standard.

Report compiled by: Heather Caudle, Associate Director of Quality on behalf of Philip Beesley, NED Chair of IGAC

Date: 12th April 2012