MINUTES OF INTEGRATED GOVERNANCE COMMITTEE
HELD ON TUESDAY 28 AUGUST 2012
HOLLYFIELD ROAD, SURBITON

PRESENT:
Dr Phil Moore (PM) IGC Deputy Chair
David Smith (DS) Chief Officer, Designate
Dr Naz Jivani (NJ) Governing Body Chair, Designate
Brian Roberts (BR) Information Manager
David Knowles (DK) Lay Member
Dr Pete Smith (PS) Governing Body GP
Neil Ferrelly (NR) Chief Finance Officer, Designate
Julia Billington (JB) Governing Body Nurse
Jill Pearse (JP) Head of Governance & Business Support
Diana Childs (DC) Kingston Healthwatch

IN ATTENDANCE:
Dr Ruth Chapman (RC) Designated Nurse for Safeguarding
Chris Robjohn (CR) Safeguarding Lead
Laura Jackson (LJ) Business Manager
Jo Dandridge (JD) Business Support
Caroline Blyth (CB) Business Support

APOLOGIES:
Jonathan Hildebrand IGC Chair
Mike Chester Secondary Care Specialist
Tonia Michaelides Chief Operating Officer, Designate
Yarlini Roberts Finance Manager
Paul Gallagher Lay Member
Dr Junaid Syed Governing Body GP

1. Welcome and Introductions: Those present were welcomed to the meeting by the Deputy Chair.

2. MINUTES OF LAST MEETING – 31 July 2012
These were agreed as an accurate record.

3. MATTERS ARISING
The committee went through the actions log from the 31 July and status of items.

12.04.02 Claims liability: JP reported that a response from NHSLA was awaited.

12//09 JP to provide bullet points on risk lead role action to be carried forward.

Date: 31 07 12
12/03.03 JD to continue to liaise with Debbie Stubberfield on any information or reports on falls resulting in death.

4. **Safeguarding Children Review update**

Chris Robjohn, designated nurse for safeguarding, presented the Safeguarding Children and Young People report with specific reference to the recent OFSTED / CQC inspection. There is a new interim management structure in Richmond Local Authority led by Nick Whitfield, Barbara Murray and Andrew Sutton, a new manager for Looked After Children (LAC). CR to meet in 2 weeks.

CR reported that there is a working party that will evaluate the 4 tiers of need within health. CR will be a member of the working party.

There is increased activity in the 0-19yr service and a business case for the commissioning of a Designated LAC Paediatrician at Moor Lane Centre to ensure leadership of the LAC team for health. An advert for a designated doctor has been posted and interviews will take place in Sept. There have been two applicants. CR will be on the interview panel.

**Recommendations**

CR reported that a final action plan would be submitted by 7 September 2012. DS said that the council had set up an Improvement Programme Board, where the action plan would also be monitored and linked up with the overall OFSTED plan. Also there would be provision within the structure for a designated doctor/medical director that would report into the governing body. This reporting mechanism would need to be reviewed in time.

DS said that one of the areas the RBK is looking at is to set up a new Rapid Access Team that would be a single point of access. There is a cost attached to this, as it would involve placing a police office and a health visitor/social worker within the structure in order to streamline it. Health would pick up the cost, as there is a statutory duty on health for a designated health visitor, which then goes to the NHS Commissioning Board. The question remains on whether this is a 1H year cost or a new way of working.

LB raised cross-border concerns seen between the boroughs of Kingston and Surrey, where Surrey has not been cooperative in releasing information and has been using data protection as a reason not to release information. The Group stressed that child protection overrides confidentiality and if critical information is not made available, this is a major area of risk. The group requested assurance that this is going to be resolved for the next meeting. An update to occur at each meeting and possibly escalation to Chief Officer level.
ACTION: PS to discuss with CR on the information release issue and report back on progress at next meeting.

5. **CCG Authorisation – Key Lines of Enquiry**

PC presented the Quality and Patient Safety report.

**Item 1-2.** The committee discussed how the CCG will triangulate and integrate potentially fragmented quality data. NJ said that there needs to be a process where CQRGs will look at patient outcomes on the metrics of providers.

**ACTION:** PC to look at possible process that needs to be put in place

**Item 3.** PC asked how the CCG will pull together all the different sectors into one place. PM noted that the committee should be notifying the governing body on areas of concern within the contractual process that includes CQUINS.

Committee members discussed the large amount of information it is required to examine, which means the quality issue is not sufficiently grasped to provide adequate feedback to the governing body.

PC reported that in the new CCG structure there will be a designated Quality Management post. Questions remain about how to bring in any information that Health Watch may have and patient experience. NJ noted that some elements are going to the CQRG, but not all, as that would require someone in post to sift through the information.

There were also questions over how to monitor quality of providers who don’t have CQRGs. LJ raised the point identified in a SWL workshop that if you have people placed out of area and in other care then it is not possible to have quality reports from everyone. This situation requires trust that the host commissioner is doing all the necessary checks.

PM suggested a mechanism was needed where problems are picked up even if they are small and the use of the risk register should synthesise things well enough to reassure the governing body.

**ACTION:** PC to meet with JP, LJ and NJ (for clinical input) to draw up idea of process. PM would also like to be involved to some degree. NJ was seen as the likely lead on this for 19 Sept meeting.

**Complaints Policy**

**Item 8.** PC noted it may be necessary to look at the complaints policy and governance report over the next 6 months. The committee agreed that CQUINs should be picked up by CQRG as a key area of quality.

**ACTION:** PC to work with JP on this area.
Item 19. Insufficient information on the SI system.
ACTION: PC and JP to meet and discuss.

Item 9. Currently feedback on services is done through cluster, but in time responsibility will transfer to the CCG. YHC has a low level of SI’s, but there are concerns over resource issues.

DS pointed out that there needs to be clarity and some kind of assessment on whether something is a risk or not. PM said it would preferably be in the form of a report rather than minutes.

ACTION: PM to liaise with JD on writing to those responsible in the CQRG that the IGC would like to receive both their minutes and sub-group report.

6. RISK MANAGEMENT

Corporate Objectives
JP presented a list of corporate objectives based on the 6 domains that had been in the CCG authorisation guidance and the previously agreed strategic goals of the CCG. They were accepted with the addition of a 7th that looked at managing a ‘safe’ transition. Further work to be undertaken to develop more detailed, measurable outcomes and workstreams around the domains and their deliverables.

ACTION: JP to develop objectives

Risk Management Policy
The committee agreed to adopt the SWL Policy policy as an interim measure until it is reviewed at a later date.

Risk Management Strategy
The strategy was accepted, although it was recognised that this area was an ongoing piece of development work. The committee discussed the benefit of efforts to streamline the strategy and to gather patient and staff narratives, combining both policy and strategy documents.

Risk Register
JP presented the Risk Register which is now in 3 parts: CCG, PCT and Public Health. An overall summary chart was also presented and agreed to be useful - column at the end to be added for developments, e.g. if anything had been escalated and specific issues to observe. There were concerns over how to gather the information and the consequences of publishing this information.

No extreme risks are currently identified

Risk 314 has been reduced to high from extreme. At a previous meeting it was agreed to triangulate this with the RBK risk register. RBK had registered it amber, as they have a
different risk rating to the CCG, however RBK said they were going to examine their risk measures. After discussions with RBK, it was agreed that if an action plan was put in place then the risk could be reduced. The Group were in agreement that ‘high’ was the appropriate level for the risk and that this risk needs to be pursued by the LSCB.

**ACTION:** PM to write to the chair of the LSCB and copy in Nick Whitfield and Anne Gallloway.

PS noted that the halving of the ISiS team needs to be flagged as a risk (possibly a high risk) and within the summary. It was discussed whether there needed to be a short-term process developed where there is triangulation and a more accessible risk register that everyone can have access to.

**ACTION:** JP to add ISIS as a separate item and look at how to make the risk register more of a active document.

Another area to focus attention on now relates to mental health, but is this progressing. PM reported the formation of a Clinical Governance Group that is set to meet with the Clinical Commissioning leads of all 5 CCG’s.

**ACTION:** PM to update JP on issues related with mental health.

PM noted that there was no indication of the improvement of consistency in engagement within primary care. NJ suggested that Part 2 looks at quality issues within practices, where performance issues can be fed through to the committee.

**ACTION:** JP to consider.

BR noted there were risks around the provision of information from the CSU. The committee agreed this was a “major issue”. PM to discuss during current negotiations with the CSU so there is a process of monitoring that cuts across all categories. This would be a by-pass route beyond the OMG so it is flagged. Risk had been added to the risk register.

**ACTION:** PM to report back after discussions with CSU.

### 7. Policy Management

JP recommended a pragmatic approach in adopting policy going forward. Cluster has devised a new list of about 33 policies since its inception, however there are issues around local implementation. DK said that it needs to be rationalised and slimmed down and assurance these things are in place. It is not necessary to see the document, but a communication on the status would be useful, including the incorporation of an updating date. It was agreed that a one page key point summary with policy/process backing it would be a useful way forward.

**ACTION:** Policy status report to be drafted by JP.

### 8. Performance Report

BR presented the performance report.
18 weeks: Kingston is largely on track, but StG are having significant problems meeting this target. Provided Kingston achieves this, the target will be achieved. Activity measures – referrals are down and pulling back to normalisation, largely due to QIPP, which hasn’t affected outpatient attendances yet. Outpatient performance should normalise too.

It was noted that there appeared to be significant change in a short space of time.

**ACTION:** BR to look at distinguishing issues related to safety, experience and quality within the performance report

9. **Reducing Pressure Ulcers in Care Homes**

LB reported funding that is available across the 5 PCTs to look at a harm-free pilot with funding for 100 beds. The money also provides funding for a top 8a tiered nurse will be appointed for a one-day a week secondment. This one-day-a-week post will report into borough and SWL and could be a good platform to start from. This has been approved by DS/TM.

JB reported that she and JP were looking into pressure ulcer reporting and wound management in nursing homes. There is a 2012/13 care home initiative that has been commissioned with a predicted £600k potential saving. £100k has been commissioned for a hospital avoidance scheme whereby a band 7 nurse will go into selected nursing and care homes to offer support and education around specific areas of care. Although the nurse has not yet started, Amanda Gunner has been working closely with the lead nurses/matrons from these homes.

JB and JP have arranged a lead nurse meeting for the nursing and care home leads on 12th September, the aim of the meeting is to look at pressure area care, wound management and reporting grade3/4 pressure ulcers. Initial response from some care home leads has been to want to talk about other agendas namely they do not have GP access they can rely on.

It was suggested that it would be worthwhile to talk with RBK, continuing care team and Jane Bearman regarding this area. PS said it would be useful to ask GP’s what their concerns are regarding specific homes.

**ACTION:** JP and JB to attend meeting and report back.

10. **Minutes/Reports**

**S1** Kingston Hospital Clinical Quality Review Group
Minutes of the meeting held on 15 August 2012 were received.
S2  NHS Kingston & Your Healthcare Clinical Quality
The review and quarterly update was received.

S3  Safeguarding Adults Sub Group report
The report was received and discussed.

S4  Olympic Steering Group
Minutes of the 15 August 2012 meeting were received.

S5  Medicines Management
Minutes of the 8 March 2012 meeting were received.

12.  ANY OTHER BUSINESS
None.

13.  DATE OF NEXT MEETING
Tuesday, 25 September 2012 (4-6pm) at the Groves Medical Centre, New Malden.

Chairman………………………………………………..  Date……………………………………