West Hertfordshire Hospitals **NHS**
NHS Trust

Agenda 21/10

Minutes of the General Governance Committee (GGC)
Thursday 26th November 2009
8.45 – 10:00 am, WGH Executive Meeting Room

Present:

Mahdi Hasan	Non-Executive Director (Chair)	MH
Colin Johnston	Medical Director	CJ
David Evans	Respiratory Consultant / Audit Lead	DE
Andrew Barlow	Clinical Lead – Oncology	AB
Tony Divers	Clinical Director – Radiology	TD
Martin Keble	Chief Pharmacist	MK
Nick Evans	Director for Partnerships	NEv
Russell Griffin	Clinical Director – Surgery	RG
Sarah Childerstone	Director of Workforce	SC
David Griffin	Clinical Director – Gynaecology	DG
Phil Bradley	Deputy Director of Finance	PB
Robin Wiggins	Clinical Director of Pathology	RW
Susan Osborne	Interim Director of Nursing/Patient Services	SO
Kevin Rosenfeld	MSC Chair	KR
David McNeil	Director of Corporate Affairs	DM
Emmanuel Quisttherson	Consultant Paediatrician	EQ

In Attendance

Nick Egginton	Clinical Governance & Risk Manager	NEg
Sirajul Islam	Clinical Governance & Risk Manager	SI
Pamela Mudie	PA Clinical Governance & Risk	PM

Item		Action
1.	**Apologies for Absence**	
	Mark Jarvis Associate Dir. Integrated Governance	
2.	**Matters for Discussion**	
	The Chair opened the meeting and confirmed the status of the Committee as a formal Board Sub Committee, chaired by a Non-Executive. It was noted that to ensure that all meetings are quorate it would be necessary to nominate an additional non-executive to deputise in the absence of the Chair.	*Action: DM to discuss with Thomas Hanahoe (Chair of the Trust Board) and the name of the Deputy Chair to be announced at next meet*
	2.1 Terms of Reference and Membership The Chair noted the draft terms of reference and that membership should be as for the Clinical Quality Committee (CQuaC) but with the addition of the Director of Strategy and Infrastructure. SC was concerned about the size of the membership and it was agreed this would be addressed later in the meeting	
	DM noted that this committee provides assurance to the Board but he would like the word 'integrated' to precede 'assurance'.	*Action: DM to review and amend accordingly.*
	DM also clarified that the Trust needs to set up a Carbon Reduction and Sustainability Committee and suggested this group should report to the General Governance Committee, particularly on Carbon Reduction Strategies and other sustainability issues. CJ stated that there is a Clinical and a Risk impact to the carbon reduction agenda and it is reasonable that it comes under this committee. It was agreed it was not necessary to include Carbon Reduction in the terms of reference but to ensure the	

Carbon Reduction and Sustainability Committee is included as a reporting Committee.

SC asked for clarity on the authority of this Committee and MH said he feels the main authority is as an over-sight committee to provide reassurance to the Board. There is no authority to give directions on how to deal with any concerns or which direction to go in. The Board has that authority. Jan Filochowski and CJ can discuss issues and give an executive direction to the Board.

The Chair accepted there is a potential overlap between this Committee and the Audit Committee and noted he would liaise with the Chair of the Audit Committee to prevent duplication to the Board.

Accountability & Reporting Arrangements
Groups that will report directly into the GGC will include
▪ Clinical Quality Committee (CQuaC)
▪ Carbon Reduction and Sustainability Committee
▪ Information Governance Group (IIGG)
▪ Health and Safety (H&S)

Responsibilities
First suggested bullet point was removed as captured by second.

Updated ToR attached

2.2 Risk Management
– its role in WHHT's operations and strategic direction
MH noted the Board discusses Strategic Risks ie of not becoming a Foundation Trust, not meeting financial targets etc whilst clinicians discussed different risks. MH feels they are interlinked as the clinical side generates the finance for the strategic risks and the Foundation Trust work etc

MH sees the General Governance Committee as having an agenda which looks overall at the alignment between intellectual and day-to-day processes of risk management.

The role of this Committee is to take the knowledge and experience of the membership of this group and use that to anticipate potential risks. The Chair noted he would expand on this at the next meeting, noting there were many lessons to be learned from industry (Piper Alpha, etc).

PD suggested that the recent report on governance failings at the Mid Staffordshire Foundation Trust provides a good example of risk management and risk assessment failings in the health setting, particularly given its Foundation Trust status.

SO said that there is a financial downturn coming and there is going to be a need for a national change in culture in relation to key financial decisions, particularly the tension between the need to lower headcount whilst ensuring that high standards of clinical care are maintained. There will need to be an overarching integration because unless Trusts work with PCTs and other agencies they are not going to make savings.

DM asked whether the Board would consider discussing with this Group potential impacts of any financial decisions before implementing, for instance the introduction of a ban on overtime and the implications of that. MH said that financial decisions and risk assessment should be an integral part of the decision making process. If decisions are too finance biased, it causes mishaps or serious incidents in the clinical sense and the Board has to be responsible for that too.

The problem might be that there will not be enough time to do all this in a

Action: MH suggested that everyone consider these points and follow up about membership at the next meeting.

one- hour meeting which takes place bi-monthly. The Chair acknowledged this and suggested focused workshops might be used to address particularly complex decisions.

DG noted the concerns expressed about the size of the Committee but felt that membership should initially be broad based as this Committee is a relatively new concept within the Trust.

PD asked about the relationship between Business Integrated Standards Executive (BISE) and the Divisional Integrated Standards Executive (DISE). Her understanding is that they become conduits of risk related information and assurances received. She believed that where there are locally intractable issues these should be escalated to this Committee. CJ agreed that the Divisions focus on their own issues or cross divisions and that BISE can review these in the round and where appropriate escalate to the General Governance Committee, and if appropriate, for prior review by CQuaC.

2.3 Information Technology

2.3.1   Infrastructure Risk Issues

2.3.2   Patient Identification Issues
        .
2.3.3   Standards for Better Health Compliance

 CJ noted his concern about the following specific risk issues   relating to IT highlighted by a recent incident and the wider risks and potential impacts:

- The infrastructure for IT
- Temperature controls causing the systems to crash
- Out-of-hours maintenance contracts – the incident revealed there was no formal contract for out-of-hours maintenance.

NE responded
- NE noted that IT cover for Out of hours Services is an ongoing problem. The Trust's network engineers provide on-call support but there is no 24/7 support to replace or repair either hardware or system software failures. Hardware failure support can contracted, but at a price. The concern is if there is a software problem, we do not have the expertise to repair the 40 or so programmes in the Trust. There is currently no money for this but funding will be required. Information Governance may take this but will need feedback from the Clinicians.

- Infrastructure. Several projects are underway and NE acknowledged that server capacity and air conditioning must be upgraded. The IT infrastructure is not fit for the complexity of the Trust, indeed for a 21st Century health organisation. NE acknowledged this could become a Strategic Risk. There is a 5-year IT Strategy, and we are 18 months into this, but behind on funding.

- Clinical Support's Standards Executive and current status on development of Order Comms. CJ noted concerns around a single Patient identifier and that many records have two or three identification numbers and two or three sets of case notes. CJ noted this not only presents a risk to optimum care but is not compliant with national standards where we should be using one single NHS number.   CJ noted the Trust failed the CAS alert litmus test on Wristbands because we had not met the 2008 target for use of NHS number as a single patient identifier.

NEv commented that there is a specific requirement that the Trust has to

	Action : MH asked that IIGG takes the initiative and get the information and NEv to report back to the January GGC on the status.
	Action: NEv to review the Infrastructure Report and report back to this meeting.

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<td colspan="2">have validated NHS numbers for each of our patients as a primary identifier, and noted the Trust is now meeting this requirement and indeed is some way ahead of other Trusts in the region.

NEv noted the main problems relate to inter-linkages between different IT systems. The Patient Master Index checks twice a week all the NHS numbers against the National Database. Other systems that draw numbers from PAS (Patient Administration System) also record validated NHS numbers eg Infoflex etc. Some others do not hold validated numbers, especially Pathology, which has an un-validated database. This system allows independent registration so it is possible to input patient information directly into the system and this has led to discrepancies between the Pathology database of 600,000 + and PAS. NE noted this will be a major problem in implementing the new Pathology system but is currently being addressed. CJ commented that on a clinical day-to-day basis self generated hospital numbers are often in duplicate or triplicate. NE said this is due to Medical Record Systems, which are still not properly integrated.

Health and Safety

SC said she received informal feedback following the HSE inspection, which indicated that the assessors have some continuing concerns. The assessors indicated they chose not to issue improvement notices, preferring to work with the Trust to achieve further improvements. The inspectors did compliment the Trust on the improvements that have been made from a very low start in 2006 but noted the need for further improvement in the following areas:

                                Stress at work

              Violence & aggression

              Moving & handling

SC noted that an Accelerated Action Group is being set up with Russell Harrison, Sarah Wiles and herself, being the three directors with responsibilities in the areas of concern.

MH said this had been to the Board and there is a lot of recognition of the amount of work undertaken and the improvements achieved in the last 2-3 years although it is still a challenge for the future.

Mandatory Training

SC noted this information is now reported routinely via the Trust's Performance process through the PMO. SC highlighted that their current compliance levels are improving and it is anticipated there will be 70% of compliance by the end of March. The Trust is on target in most areas apart from Conflict Resolution, Safeguarding Children at level 2 (although it is acknowledged there is under-reporting of training), and Non-Patient Moving and Handling. SC noted the target is achievable if staff complied with requirements to attend, noting the worst divisions by far are the Corporate Division and also the Consultant group.</td>
<td>*Action: Item to be put on the January agenda for more discussion.*

Action: SC will feedback key issues in the HSE formal report, which should be received in time to feedback at the next meeting of the GGC.</td>
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<td>3.</td>
<td colspan="2">**Items for Noting**</td>
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<td colspan="2">Reports & Minutes

Health and Safety Committee – Tuesday 6th October 2009</td>
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<td>4.</td>
<td colspan="2">**A.O.B**</td>
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<td colspan="2">None</td>
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<td>5.</td>
<td colspan="2">**Date of next meeting**</td>
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<td colspan="2">Thursday 21st January 2010   8.45 – 10:00 am WGH, Executive Meeting Room</td>
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