Agenda Item:

Board of Directors Meeting Report

Subject: **QUALITY GOVERNANCE FRAMEWORK**

Date: **30TH OCTOBER 2014**

Author: **SHIRLEY A CLARKE, DEPUTY DIRECTOR OF CORPORATE SERVICES**

Lead Director: **KERRY ROGERS, DIRECTOR OF CORPORATE SERVICES/ COMPANY SECRETARY**

Executive summary

Monitor wrote to the Trust after the January 2014 progress review meeting reiterating that the Trust has failed to meet its Discretionary Requirements with respect to quality governance, having been externally assessed in January (by PWC) as having a quality governance score of 4.

The Board reviewed the evidence at the March 2014 meeting and approved a reduction in the score of question 3c from 0.5 to 0.0 reducing the Trusts overall score from 4.0 to 3.5. The trust wrote to Monitor at the end of March with the evidence of the improvement and the results of this self-assessment. The Board reviewed further evidence in respect of question 3a in July and approved the recommendation of the Trust Management Board to reduce the score to 0.0, reducing the Trusts overall score from 3.5 to 3.0.

The executive leads will scrutinse the individual QGF questions against the best practice recommended by Monitor taking into consideration the impact of the recent CQC and KPMG reports, and recommend any changes to scores or trajectories to the Trust Management Board for approval prior to submission to the Board in October 2014

A review of the trajectory for achievement of a score of 0.0, in September 2014 indicated question 4b – *Is the board assured of the robustness of the quality information?* be scrutinsed to assess achievement against best practice, the report provides the detail and TMB recommends the score remain at 0.5 with an extended trajectory to March 2015 to ensure all the elements of collaborative working with external organisations including the Trusts 'buddy' trust, Newcastle University Hospitals NHS Foundation Trust can be fully embedded and sustained.

It is now prudent to revisit the QGF. This will complement the Board Health Review being undertaken by Foresight Partnership. In order to ensure a comprehensive self-assessment it is proposed to include the wider leadership team. The report proposes the process recommended by TMB.

Recommendations

1. The Board is invited to approve the recommendation from TMB for question 4b to remain at a score of 0.5
2. The board is invited to approve the recommendation from TMB to revise trajectories for questions 1b and 3b to November 2014, 2a to December 2014 and 4a and 4b to March 2015 and recommend to Trust Board

3. The Board is invited to note the update to actions to deliver the trajectory to reduce the Trusts QGF score further as indicated.

4. The Board is invited to approve the recommendation from TMB for the process for self-assessment against the Quality Governance Framework with the wider leadership team.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high quality care	**Build successful relationships with external organisations and regulators**
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	
Details of additional risks	n/a
Links to NHS Constitution	Duty of Quality
Financial Implications/Impact	
Legal Implications/Impact	Failure to deliver robust quality governance increases likelihood of continuance of Regulatory enforcement action
Partnership working & Public Engagement Implications/Impact	n/a
Committees/groups where this item has been presented before	n/a

REPORT

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Background

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Development of an Improvement Trajectory

The table below indicates the progress to date against each of the QGF questions including those which have already achieved a score of 0.0 where an update is available and the evidence which supports this score provided by the executive lead.

Board members should use the detail of the evidence provided below together with intelligence from quality assurance visits, CQC assessment of the Trust, appropriate external reports and board and committee papers to assure themselves the score reflects the current situation and that the trajectory is achievable.

	QGF Question	PWC Assessment Jan 2013	TB Self-Assessment Oct 2013	PWC assessment Jan 2014	Oct Position	Date forecast to achieve score of 0.0	Executive Lead
1a	Does Quality drive the trust Strategy?	1.0	0.4	0.0	0.0	Jan 2014	P Wozencroft
	April 2014 update The Patient Safety and Quality Strategy which identifies the quality priorities for the Trust was approved by Trust Board in March 2014. 'Plan on a Page' was approved at the Trust Board meeting in March 2014 and has subsequently been further improved and adapted. It is being used in the 'Quality for All' presentations which are being rolled out across the Trust. The Trust is active in the 'Better Together' Programme Board and full details of the programme and its constituent programmes have been discussed and agreed at a board to Board meeting between the Trust and its two local CCGs.						
1b	Is the board sufficiently aware of potential risks to quality?	1.0	0.5	0.5	0.5	Original July 2014 Revised November 2014	K Rogers
	April Update The Board receives updates of the Board Assurance Framework at each meeting. The Audit and Assurance board sub-committee also reviews and escalates where appropriate relevant risks from the corporate risk register. The monthly and quarterly quality reports presented to board detail, complaints, incidents, claims and serious incidents identifying themes and the potential impact on quality. **May Update** The BAF report is being refreshed and updated in order to provide the Board with a more robust and systematic way for them to be assured of achievement against the Strategic Objectives. **June Update** The Board Assurance statement is submitted to the Trust Board twice a year, in March and September. A revised process for the management of the BAF has been approved by the Audit and Assurance						

	Committee which included details of the role of the lead executive committees, TMB and the Audit and Assurance Committee, in challenging new board assurance report to assure themselves that the strategic objectives will be delivered. It is planned that a pilot board assurance report will be presented to the Audit and Assurance Committee for approval 24th July 2014 and to the Business Planning and Investment Committee thereafter. The Board Assurance Framework and Corporate Risk Register will have started to go through the new process before the production of the September Board Assurance Statement in September 2014. **July Update** Enhancing focus of quality and performance reports with regard to exceptions requiring more expedient action/decision. Further work with Newcastle to understand and learn from good practice with regard to the reporting of quality and risk Clarity regarding Board Development sessions in Q3 regarding the link to clinical and quality governance and the risks Co Secretary and Chairman commenced a BAF review to align with the recently published 5 year strategic plan which will be presented to BoD for formal approval in due course, following which executive leads will report through the Audit and other Board committees through the new assurance process **September update** Reinvigorated Board Assurance Reporting process to inform the Board Assurance Framework submitted to Audit Committee for approval. Principal risks identified and agreed, exec lead for each principal risk will develop comprehensive board assurance report for submission to Audit Committee to provide assurance risk is being managed and mitigated, identifying gaps in control and assurance. **October update** The exec lead for each principal risk is presenting their Board Assurance Report to TMB in October to ensure consultation and engagement with the wider leadership team. All the Board Assurance Reports will be presented to the appropriate board committee for approval prior to submission to Trust Board in November. The revised Board Assurance Framework document will be presented to Audit and Assurance Committee in November. All quality risks to CIP schemes are assessed via the Quality Impact Assessment process within the PMO Governance structure and are signed off by the Divisional Management Teams before submitting for final approval and sign off by the Director of Nursing and Medical Director The Quality Committee has been refocused and reports to Trust Board by exception any risks indicated from the reports received by the committee e.g. Serious Incidents provided by the Governance Support Unit. The Risk Management Strategy is at the latter stages of a consultation process, and will be formally adopted imminently and along with improvements in Datix reporting capability we will start to show improvements in risk reporting and as a consequence enhanced awareness of risks to quality going forward. The Governance Support Unit will present an update on Risk Management and the Corporate Risk Register at the November Audit Committee and the appointment of a substantive Risk Manager joining in November will positively impact on risk

	management through the work of the GSU and across the wards, departments and divisions, and support a stronger escalation route to the BAF as necessary. The Divisional Performance & Delivery meetings discuss risks at service line and divisional level with information provided by dedicated divisional clinical governance leads from the Governance Support Unit. Risks are reported to TMB by exception and through the escalation process. The board receives monthly Integrated Performance Reports which highlight prospective quality and performance risks on the first page. TMB committee Terms of Reference set out that committees must receive and discuss risks as appropriate to that committee and report by exception to TMB via the escalation process. Executive Directors and NEDs undertake IAT visits which provide front line evidence of risks and mitigations at ward level, this knowledge is used by the Board to triangulate with the reports received. Positive and negative quality assurance provided by external agencies is used by the board to identify areas of good practice and action plans are developed to address areas of concern, in terms of the recent CQC report these actions have been integrated into an organizational improvement plan which has been supported by the Monitor appointed Improvement Director.						
2a	Does the board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	1.0	0.2	0.5	0.5	Original Sept 2014 Revised Dec 2014	K Rogers
	April Update All board sub-committees are chaired by and have NED representation. Monthly quality reports and quarterly patient experience reports identify themes and learning from complaints and incidents. 'Plan on a Page' was approved at the Trust Board meeting in March 2014 and has subsequently been further improved and adapted and is not being used in the 'Quality for All' presentations being rolled out across the Trust. The Trust board self-assessed against the Quality Governance Framework in October 2013 at 3.9 this was externally validated by PWC in January 2014 as 4.0. In March 2014 the board received evidence and approved a further reduction in the score to 3.5. A trajectory of when each question will achieve a rating of 0.0 has been presented to the Board in April 2014. All board members take part in internal assurance visits to wards and other clinical areas. Board development Programme began on 23rd January, facilitated by Foresight Partnership (authors of the Intelligent Board). Following this event a programme of development time out sessions have been included in the annual meeting scheduler and a proposed Board development timeline was included in the Chairman's Report to Board in March 2014 A Confirm and Challenge programme has been implemented which enables the board to receive and challenge evidence provided by the divisions and executive team in relation to quality,						

	performance and risk issues across the trust in order to drive the focus of future board and subcommittee agendas. **May Update** Monitor recently issued guidance in respect of 'Well-led framework for governance reviews'. This is based on and expands the 10 QGF questions and includes a self-assessment process. It is envisaged the Board will carry out this self-assessment process during the summer in order to identify potential areas of weakness which will be addressed through the development of a detailed action plan which will be monitored through monthly reports to TMB and Board. The board effectiveness review which is scheduled towards the end of the year will provide an external assessment and report. **June Update** A Board Development Masterclass is scheduled for 27th June in respect of Data Quality the session will include: why measure? why variation matters? Run and SPC charts and how to read them, Can I trust the numbers? etc. A board effectiveness review which is scheduled in Q3, will be undertaken by Foresight. **July Update** Masterclass took place in July attended by Board members and senior colleagues Clarity regarding Board Development sessions in Q3 regarding the link to clinical and quality governance Further work with Newcastle under the buddying arrangements to support developments in the executives thinking regarding focus and presentation of information to Board Positive commentary concerning the Board and Well led domain captured in the CQC report **September Update** Board Development programme and timelines agreed with external supplier. Surveys for board members and external stakeholders issued, one to one interviews and focus groups organised. Feedback sessions and workshops arranged for December 2014. **October Update** The Board Development programme has commenced and is progressing in line with agreed timescales. The executive team is commencing team and individual coaching in October 2014. It is considered appropriate to extend the assessment of a zero score pending completion of the Board Development phase starting in October, which picks up best practice as articulated in the Healthy Board and Monitor Well Led publications, the outcomes of which will help externally assure our position as a Board with regard to this element of the QGF.						
2b	Does the board promote a quality-focused culture throughout the Trust?	1.0	0.4	0.0	0.0	Jan 2014	K Fisher
	April Update There is evidence that the board does drive the quality agenda, this is particularly evident in						

	Quality for All activities and patient stories, which are heard at each Trust Board. The implementation of the Raising Concerns - Whistleblowing policy will further encourage staff to raise concerns - the intranet site will be up and running this week and the designated officers under the policy have received the necessary training from Public Concern at Work.						
3a	Are there clear roles and accountabilities in relation to quality governance?	1.0	0.4	0.5	0.0	July 2014	P O'Connor
	April and May Update The sub-committees to the Board have been revised and implemented from April 2014, this includes a Quality Committee which is chaired by a NED with a clinical background in primary care and public health. The Executive team have developed and agreed an accountability matrix. A substantive Head of Governance is in post and the Governance Support Unit restructure is agreed supported by approved Job Descriptions which are being advertised and recruited to. There is a focus on quality on board meetings where a patient story is heard each time and where quality is the first key element of the agenda supported by a comprehensive quality report. The substantive Medical Director will be full time with the Trust from June 2014 **June Update** The Executive Medical Director will formally take up his post substantively from 30th June. This concludes the actions in respect of this QGF question. Therefore a more detailed assurance report will be presented to TMB for recommendation to the Trust Board to reduce this score to 0.0						
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	1.0	0.5	0.5	0.5	Original Sept 2014 Revised Nov 2014	M Ashworth
	April Update Revised process escalation and response process with regard to SUI's is being presented at TMB in April 2014, including triangulation of information between, SUI's, incidents and complaints. Investment in Datix system will enable richer reporting of information Clinical audit and effectiveness group was launched 16th April 2014 with a strengthened focus on clinical audits. Strengthened focus on 'fitness to practice' performance management approach.						

	May Update SUI process approved at TMB on 22nd April and Quality Committee were assured at their meeting on 22nd regarding the revised process. The committee has requested an update on the process in 3 months' time. Revised Datix system for incidence module is going live from 1st July. The risk module will go live on 10th July starting in EC&M and the complaints module is currently being scoped with the Head of Complaints, Jill Faulkner and the datix project manager with a view to go live in August To support triangulation of learning the GSU restructure includes divisional clinical governance co-ordinators. 3 tentative appointments have been made to the outstanding divisions following interviews held on 22nd May. **June Update** Clinical Audit and Effectiveness Sub-Committee has been re-established and the clinical audit forward plan is being reviewed and prioritized to ensure trust priorities are agreed within the level 1 and 2 audits. The Serious Incident reporting process has been revised. The Governance Support Unit will be fully staffed during Q2, this final action will enable assurance to be provided to TMB for recommendation to the Trust Board to reduce the score to 0.0 **July Update** The revised Serious Incident reporting process, the structure of the GSU once all vacancies filled will ensure this standard is met. **September Update** GSU structure progressing, substantive Risk Manager to start Nov 2014. Patient Experience module on Datix being piloted in EC & M to be rolled out across wider organisation. **October Update** The 'other' category has been removed from the incident reporting system to enable a richer level of reporting increasing the opportunity to identify themes and trends. One to one training has been undertaken by the Clinical Governance Lead to ensure intelligent completion of the lessons learned and implemented section.						
3c	Does the board actively engage patients, staff and other key stakeholders on quality?	1.0	0.4	0.5 (revised to 0.0 by TB in March 2014)	0.0	March 2014	S Bowler
	April update Patient Safety and Quality Strategy developed through outputs from 'In Your Shoes' patient						

	engagement events, approved by Trust Board March 2014 Quality priorities for 2014/15 developed through engagement via 'Quality for All'. Director of Nursing and CEO met with Healthwatch and agreed to develop a closer relationship, Healthwatch representative invited to attend Patient Experience Committee.						
4a	Is appropriate quality information being analysed and challenged?	1.0	0.3	0.5	0.5	Nov 14 Revised to March 2015	J Tufnell
	April – July update Monthly Integrated Performance Report includes data and information on Monitor Risk Assessment Framework standards, Quality and Safety and Patient Experience. Quality data reports are submitted to board sub-committees chaired by NEDs prior to submission to the Board. Quality information in challenged through the divisional clinical governance process, however further work is required to fully embed and sustain the ward to board flow of information. The Trust need to develop a process of producing quality information at consultant level **September update** A review of the Integrated Performance Report currently utilised, will be subjected to a complete evaluation by internal audit. This will include how adequate are the performance arrangements to the Board, presentation of the information and cascade and escalation procedures of performance measures. **October update** The Audit and Assurance committee agreed that in light of the development of an action plan to address the recent KPMG review and the ongoing work with Nottingham University Hospitals in developing a Kitemark quality indicator together with collaboration with Newcastle Upon Tyne University Hospitals regarding improvements to data quality the audit of the Integrated Performance Report would be deferred to Q4 2014/15. Therefore the trajectory for this question has been revised to March 2015						
4b	Is the board assured of the robustness of the quality information?	4.0	0.5	0.5	0.5	Sept 14 Revised to March 2015	J Tufnell
	April – July update A Data Quality group and committee chaired by the Director of Operations has been implemented and include representatives from GSU, HR, Clinicians, Information team, infection control and divisions. A data quality 'kitemark' is currently being developed to RAG rate the quality of the data presented. The Trust is working with Newcastle to review information processes and provide improved						

assurance in relation to the accuracy of information. Medway PAS is still planned for roll-out in October which will significantly improve our input (with all staff receiving training) and its reporting capability. A further consequence will be the ability to improve the resources in the data quality team by moving staff from information

September update

It has been agreed that the Monitor Risk Assurance Indicators will be used as part of the data quality cycle.

During August and September the first indicators across six areas have been reviewed utilising the DQ kite Mark approach.

The six areas include:

- Staff Training/Standard Operating Procedures
- Timeliness/Completeness/Granularity
- Clinical Input and validation to data capture
- Reports are discussed and evaluated at Trust Divisional/Specialty Meetings
- Benchmarking/Published Data availability
- Subjected to Internal/External Audit

The Trust has commenced work with Nottingham University Hospitals who use the same Patient Administrative System (PAS), in order to ensure that from October 2014 onwards report replication or organisation specific amendments will be more easily produced.

The Head of Information visited the Trusts' buddy trust, Newcastle upon Tyne Hospitals FT and a number of learning points have been implemented, resulting in more detailed clinical notes within patient case-notes recorded leading to a greater coding depth and accuracy improvement

October update

The table below shows the self-assessed RAG rating against each element.

4b	**Is the board assured of the robustness of the quality information?**	
	Examples of Good Practice	
	There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness	
	Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the board of the quality of its data	
	Clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents)	
	Electronic systems are used where possible, generating reliable reports with minimal ongoing effort	
	Information can be traced to source and is signed-off by owners	
	There is clear evidence of action to resolve audit concerns	
	Action plans are completed from audit (and subject to regular follow-up reviews)	
	Re-audits are undertaken to assess performance improvement	
	There are no major concerns with coding accuracy performance	

In light of this self-assessment it is proposed Question 4b remains at 0.5 against the QGF scoring matrix

The team continues to work with colleagues in the Trust's buddy Trust Newcastle upon Tyne Hospitals and Nottingham University Hospitals. The DQ Kitemark content has been agreed and work is progressing with the Cancer team to apply the Kitemark against their Monitor indicators for inclusion in the Integrated Performance Report (IPR). There remains a significant level of work required regarding the other indicators within the IPR. Clinical Audit are progressing actions with

	divisions and clinicians which will enable the score to be reduced over the coming months. In light of the above and in order to ensure robustness and sustainability the trajectory has been revised to March 2015						
4c	Is quality information being used effectively?	1.0	0.3	0.5	0.5	March 2015	S Bowler
	April – July update Communication Boards rolled out across the Trust including specialist areas – Children's, Maternity and Outpatients. These have been identified as best practice and the Trust has been approached by other organisations to share the process. Quality report has been presented in a consistent format, this builds the messages throughout the year. This is reported to the board meeting held in public and is available on the internet. Trend analysis of trust performance is compared to external benchmarking tools such as the safety thermometer, RAG rated and reported in the Integrated Performance Report to TB. Performance is reported the month following achievement i.e. February performance is reported in March. The Ward assurance matrix provides a drill down from Trust to division to individual ward performance and is distributed 15 working days after the month end. Falls deep dive information was presented to the Quality Committee and HSMR is reported on a monthly basis validated externally on a quarterly basis. Serious Incidents are reported as part of the Integrated Performance Report and present individual information and data to the Quality Committee such as Never Events. The focus on HSMR, Pressure Ulcers, reduction in Cardiac Arrest rates are examples of where information on quality has led to an improvement in quality performance. **September update** Positive feedback from Quality Committee in relation to quality of reports and presentations. Culture of deep dives, within governance to understand root cause Serious Incident process is strong and challenging Greater understanding of learning opportunities as sub committees Early warning dashboard being updated to reflect current quality and operational challenges **October update** Divisional clinical governance information has been reviewed and adapted to reflect divisional and service line needs. The trust has worked with the 'buddy' trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust and is adopting where appropriate the model used by NUTH.						

	All posts in the Governance Support Unit have been recruited too. The Early Warning Dashboard has been reviewed to assess measures which reflect current risks. The Ward Communication Boards 'How we are doing' have been updated to include medicine omissions and C-diff performance. The staffing section has also been updated to reflect NICE guidance

Governance review

The Trust Board undertook a self-assessment against the QGF good practice in October 2013 and scored an average of 3.9 this was endorsed externally by PWC in January 2014 and subsequently monthly updates have been provided to the Board as described earlier in this report. However In light of the CQC inspection of the Trust in April 2014 and subsequent report, July 2014 which recommended the Trust remain in special measures for a further 6 months, together with the Monitor requirement for all Foundation Trusts under the Risk assessment framework and Code of Governance, to undertake an external review of its governance every three years. It is now prudent to revisit the QGF. This will complement the Board Health Review being undertaken by Foresight Partnership. In order to ensure a comprehensive self-assessment it is proposed to include the wider leadership team and the following process has been recommended by TMB:

Action	Owner	Timeline
QGF questions and Good Practice guidance issued to all members of TMB and Trust Board	Deputy Director of Corporate Services	5th November 2014
All members of TMB and Trust Board to provide a self-assessment against each question based on RAG rating of the Good Practice guidance and return to Deputy Director of Corporate Services	TMB members	14th November 2014
Analysis of responses and prepare report for TMB, to review findings and propose actions together with a recommend score to TB	Deputy Director of Corporate Services	19th November 2014
Analysis of responses and prepare report for TB for debate and ratification of proposed score from TMB if approved	Deputy Director of Corporate Services	24th November 2014
Trust Board to agree actions in response to review and propose monitoring process e.g. confirm and challenge session	Trust Board Members	27th November 2014
Development of monitoring process as approved by TB	Deputy Director of Corporate Services	8th December 2014

Recommendations

1. The Board is invited to approve the recommendation from TMB for question 4b to remain at a score of 0.5

2. The board is invited to approve the recommendation from TMB to revise trajectories for questions 1b and 3b to November 2014, 2a to December 2014 and 4a and 4b to March 2015 and recommend to Trust Board

3. The Board is invited to note the update to actions to deliver the trajectory to reduce the Trusts QGF score further as indicated.

4. The Board is invited to approve the recommendation from TMB for the process for self-assessment against the Quality Governance Framework with the wider leadership team.