Agenda Item:

Board of Directors Meeting Report

Subject: **QUALITY GOVERNANCE FRAMEWORK**

Date: **31st July 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 Trust Management Board have reviewed the approved trajectory which shows QGF question 3a being fully assured for reduction to 0.0 in June 2014. The Trust Management Board has reviewed the evidence and recommends a reduction in the score from 0.5 to 0.0.

In order for the board to recommend a reduction in the score, they must be assured there is evidence against the good practice identified within the QGF.

Board members should use the detail of the evidence provided below together with intelligence from quality assurance visits, CCG assessment of the Trust, recent CQC report, board and committee papers to assure themselves a reduction in the score is appropriate and sustainable.

Monitor Quality Governance Framework, details good practice against each of the 10 QGF questions, in order to provide assurance regarding the reduction in the score for question 3a, listed in the report is the example of good practice and the evidence to support the assurance

RECOMMENDATION

1. The Board is invited to review the evidence provided in the report and the recommendation from TMB and approve a reduction in the QGF Score for question 3a from 0.5 to 0.0 and the consequential decrease in the Trust's overall score from 3.5 to 3.0.
2. The Board is invited to note the update actions to deliver the trajectory to reduce the Trusts QGF score further as indicated

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

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.

To monitor further progress against each of the QGF questions each question has been allocated an executive lead who will provide evidence monthly and a trajectory of when the relevant question will attain a score of 0.0.

The Trust Management Board have reviewed the approved trajectory which shows QGF question 3a being fully assured for reduction to 0.0 in June 2014. The Trust Management Board has reviewed the evidence and recommends a reduction in the score from 0.5 to 0.0.

In order for the board to recommend a reduction in the score, they must be assured there is evidence against the good practice identified within the QGF.

Board members should use the detail of the evidence provided below together with intelligence from quality assurance visits, CCG assessment of the Trust, recent CQC report, board and committee papers to assure themselves a reduction in the score is appropriate and sustainable.

Monitor Quality Governance Framework, details good practice against each of the 10 QGF questions, in order to provide assurance regarding the reduction in the score for question 3a, listed in the report is the example of good practice and the evidence to support the assurance

QGF question 3a – *Are there clear roles and accountabilities in relation to quality governance?*

Example of Good Practice	Evidence
Each and every board member understand their ultimate accountability for quality	The Executive team have developed and agreed an accountability matrix

	The recent CQC report noted that ' *NEDs had been on formal and informal ward visits over the last few months, with the executives.* The NEDs told the CQC that *their presence ensured the focus of the board was on quality over finance and gave examples of increasing priorities in certain areas of care.*
There is a clear organisational structure that cascades responsibility for delivering quality performance from 'board to ward to board' (and there are specified owners in-post and actively fulfilling their responsibilities)	The 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 operational committees have also been revised and implemented from April 2014, this includes a Clinical Quality and Governance Committee which is chaired by the Medical Director / DoN and reports directly to the Trust Management Board on a monthly basis. Divisional, medical and union/consultative representation are part of TMB membership and the granularity of ward to board reporting is fast developing with dashboards and escalations. The recent CQC report identified robust quality governance processes in a number of areas: Medicine, Surgery, Critical Care, Maternity and Family planning services, Children and Young people.
Quality is a core part of main board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions	There is a focus on quality at 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. Developments in identification of off plan performance are beginning to allow the Board to consider more timely action to recover performance. The full functioning of the GSU will support divisions in their analysis of variance thereby supporting proactive and expedient action
Quality performance is discussed in more detail each month by a quality focused board sub-committee with a stable, regularly attending membership	The Quality Committee is a committee of the Board of Directors and meets bi-monthly, although a decision to meet monthly has been agreed for a transitional period. This committee is chaired by a NED and the Terms of Reference identifies 2 other NEDs as members together with attendance by the Executive Director of Nursing and Medical Director.

	Together with regular extensive Quality Reports, the committee receives the following reports on behalf of the Trust Board: Clinical Audit Annual Forward Plan Complaints Annual Report Pressure Ulcers / Infection Control, Annual Report Privacy and Dignity Annual Declaration Quality Accounts and progress Safeguarding Annual Report Research and Development awareness Performance reporting

The criteria for the scoring is identified in the table below, in order to move to a score of 0.0 the board need to be assured that there are '*Many elements of good practice and there are not major omissions*'

	Scoring Key:		
	Definition	**Evidence**	**Score**
	Meets or exceeds expectations	Many elements of good practice and there are no major ommissions	0
	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and robust action plans in place to address perceived shortfalls.	0.5
	Partially meets expectations but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development	1
	Does not meet expectations	Major omission in quality governance identified. Significant action required with limited plans in place to address omission.	4

Development of an Improvement Trajectory

The table below indicates the progress in month against each of the QGF questions including those which have already achieved a score of 0.0 and the evidence which supports this score provided by the executive lead

	QGF Question	**PWC Assessment Jan 2013**	**TB Self-Assessment Oct 2013**	**PWC assessment Jan 2014**	**July 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	July 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						
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	Sept 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						
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	0.5	June 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 **July Update** See main body of report						
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	1.0	0.5	0.5	0.5	Sept 2014	F Steele
	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.						
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	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						
4b	Is the board assured of the robustness of the quality information?	4.0	0.5	0.5	0.5	Sept 14	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						
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.						

RECOMMENDATION

1. The Board is invited to review the evidence provided in the report and the recommendation from TMB and approve a reduction in the QGF Score for question 3a from 0.5 to 0.0 and the consequential decrease in the Trust's overall score from 3.5 to 3.0.

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