Sherwood Forest Hospitals NHS
NHS Foundation Trust

Agenda Item:

Board of Directors Meeting Report

Subject: **QUALITY GOVERNANCE FRAMEWORK**

Date: **29th May 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.

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

RECOMMENDATION

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

2. The Board is invited to call upon the work it has completed to assure individuals of the realities of the quality of care delivery at the Trust gleaned from involvement in C&C sessions, ward and department unannounced visits, IATs and other triangulated intelligence sources to inform Board's acceptance of the improvements forecast.

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 against the Keogh Actions 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.

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The Monitor guidance in respect of the Quality Governance framework identifies under each question areas of best practice, the executive lead of the question will use this information to measure progress and evidence achievement.

Development of an Improvement Trajectory

The table below indicates the progress in month against each of the QGF questions

	QGF Question	PWC Assessment Jan 2013	TB Self-Assessment Oct 2013	PWC assessment Jan 2014	May 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

1b	Is the board sufficiently aware of potential risks to quality?	1.0	0.5	0.5	0.5	July 2014	K Rogers
	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 2014 – 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.						
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
	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 2014 – 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.						
2b	Does the board promote a quality-focused culture throughout the Trust?	1.0	0.4	0.0	0.0	Jan 2014	K Fisher
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
	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						
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
	May 2014 - 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.						
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
4a	Is appropriate quality information being analysed and challenged?	1.0	0.3	0.5	0.5	Nov 14	J Tufnell
	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
	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. **May 2014 – Update** 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	1.0	0.3	0.5	0.5	March 2015	S Bowler

	used effectively?						
	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

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