Agenda Item:

Board of Directors Meeting Report

Subject: **QUALITY GOVERNANCE FRAMEWORK**

Date: **27th February 2014**

Author: **SHIRLEY A CLARKE, HEAD OF PROGRAMME MANAGEMENT**

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 it Discretionary Requirements with respect to quality governance, having been externally assessed in January (by PWC) as having a quality governance score of 4. The Trust informed Monitor it expects to achieve a score of 3.5 by the end of February 2014. Monitor expect the Trust to write to them with evidence of the improvement and the results of its self-assessment by the end of March 2014.

At the end of October 2013 the Trust Board declared its self-assessment score against the QGF at 3.9, below the threshold of 4 required by Monitor.

A programme of Confirm and Challenge Events has been arranged throughout the year to address the areas identified for improvement. The second session took place on 13th February 2014.

The session comprised of three panels. The notes from the event have been analysed into improvements evidenced, risks and mitigations, the detail is included in the report.

The Monitor guidance in respect of the Quality Governance framework identifies under each question areas of best practice. These are detailed in the report.

RECOMMENDATION

1. *The Board of Directors is invited to review the evidence provided in the report and re-score the QGF questions identified.*

2. *The Board of Directors is invited to identify and request further actions which need to be taken to evidence improvements.*

3. *The Board of Directors is invited to acknowledge that monthly progress against the QGF score will continue be provided to the Board of Directors to show progress and that the Executive Team/TMB will manage progress on a monthly basis to satisfy improvement*

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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	Obligated through our Licence to identify and manage risks to compliance with the Conditions of our Licence including the QGF
Details of additional risks	n/a
Links to NHS Constitution	Duty of Quality
Financial Implications/Impact	
Legal Implications/Impact	Failure to deliver against the QGF increases likelihood of continuance of Regulatory enforcement action
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	n/a

REPORT

Subject: **QUALITY GOVERNANCE FRAMEWORK**

Date: **27th FEBRUARY 2014**

Author: **SHIRLEY A CLARKE, HEAD OF PROGRAMME MANAGEMENT**

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

BACKGROUND

Monitor wrote to the Trust after the January 2014 progress review meeting reiterating that the Trust has failed to meet it Discretionary Requirements with respect to quality governance, having been externally assessed in January (by PWC) as having a quality governance score of 4. The Trust informed Monitor it expects to achieve a score of 3.5 by the end of February 2014. Monitor expect the Trust to write to them with evidence of the improvement and the results of its self-assessment by the end of March 2014.

Monitor define Quality Governance as the combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- *ensuring required standards are achieved*
- *investigating and taking action on sub-standard performance*
- *planning and driving continuous improvement*
- *identifying, sharing and ensuring delivery of best-practice*
- *identifying and managing risks to quality of care*

These are underpinned by four areas comprising of ten questions against which scores are allocated using the following criteria:

Score	Definition	Evidence
0	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
0.5	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
1	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.
4	Does not meet expectations.	Major omission in quality governance identified. Significant action required with limited plans in place to address omission.

At the end of October 2013 the Trust Board declared its self-assessment score against the QGF at 3.9, below the threshold of 4 required by Monitor.

The Trusts own self-assessment and the PWC external validation report identifies areas for improvement, these form part of the consolidated action plan which has been developed under the PMO governance process.

CONFIRM AND CHALLENGE

A programme of Confirm and Challenge Events has been arranged throughout the year to address the areas identified for improvement. The second session took place on 13th February 2014. The Confirm and Challenge sessions are an opportunity for Non-Executive Directors to answer the question frequently posed to the organisation by Monitor 'How do you know?' and 'How do the people you rely on for information know?'

Monitor has provided guidance for the board of NHS provider organisations:

Quality governance: How does a board know that its organisation is working effectively to improve patient care?

Board members must differentiate between Reassurance and Assurance, Monitor define it thus:

Reassurance **Assurance**

It is okay because management say It is.	*It is okay because how management have responded to questions from the board has given me confidence.*	*It is okay because I have reviewed various reliable sources of information.*
Strong management - personalities may dominate. Track record of success. Professional background or expertise No contradictory evidence.	Clear and logical explanations from board members. What has happened; why it has happened and what is the response. Management explanations are consistent.	Independence of information source. Evidence of historic progress, outcomes. Triangulation with other information.

The session comprised of three panels:

Panel 1 – Area of Focus: QGF questions 3a and 3b, Clear roles and accountabilities in relation to quality governance, including availability of current data and information to enable holding responsible people to account. Active engagement of patients, carers, staff and other stakeholders on quality.

Panel 2 – Area of Focus: QGF questions 4,a, 4b, 4c, Measurement- Is appropriate quality information being analysed, challenged and used effectively.

Panel 3 – Area of Focus: Complaints, process, sustainability and learning.

The notes from the event have been analysed into improvements evidenced, risks and mitigations:

Panel No:	Improvements evidenced	Risk	Mitigation
1	Consistent metrics across all wards. Utilised to improve performance through divisional governance meetings	Not standardised across all divisions. Interpretation of the data subjective	GSU restructure will standardise metrics enabling robust performance management through divisional governance meetings
	Ability to challenge and improve data e.g. appraisal rates	Focus on data not the issue.	Improvements in data quality
	Medical engagement in understanding metrics and performance information and utilising to move service forward	Not wide spread across all specialties	Service Line reporting and the development of specialty level business plans will support divisions to utilise metrics
	Development of the Accountability Matrix for directors had improved understanding and awareness of collective responsibilities	Clarity of accountability at divisional level not evident	Divisional accountability matrix to be developed
	Appointment of business analyst in GSU has had significant impact on the quality of data available	Role and responsibilities of GSU to be defined to support divisions	Substantive head of governance in post February 2014, restructure of GSU taking place
	Communication from board to ward, board members more visible and visits by board members are a boost.	Attitude problem of some staff recognised and also identified as a theme in complaints. Not enough time spent understanding the issues and the undercurrents	Implementation of OD Strategy with emphasis on values and behaviours
2	Consistent language used Board to ward.		
	Staff engaged with ward dashboards and feel able to challenge data	Focus on data not the issue.	Improvements in data quality
	Very proud of ward boards and metrics, creates competition to be 'the best'	Too much emphasis on 'Reds' - resulting in little acknowledgement of successes	Develop exception reporting
	Information received for	Consistency and	GSU restructure will

	governance meetings gives a clear and detailed understanding of the division	interpretation of data	standardise metrics enabling robust performance management through divisional governance meetings
	Communication and openness has developed in last 12 months and is getting stronger	Attitude problem of some staff recognised and also identified as a theme in complaints. Not enough time spent understanding the issues and the undercurrents	Implementation of OD Strategy with emphasis on values and behaviours
	Clinical audits presented at division meetings action plans agreed and monitored. Sharing of findings	Little evidence of shared learning	Clinical Audit outcomes presented at CMT.
	Data quality improved but still some challenges	Quality of data being input not robust and staff not understanding implications of incorrect or missing data.	Implementation of new PAS together with training of staff. Development of Quality wheel, 'kite mark'
		Immediate issue regarding financial information, whilst finance team in transition	Finance working more closely with Divisions to understand and resolve current issues.
3	Robust and much improved process regarding responding to complaints.	Number of vacancies within the Complaints team.	Redesigned complaints team, workforce change consultation due for completion end March 2014
	Quality of response improved as checked by Divisional Matrons prior to sending to complainant	Over reliance on small number of clinical staff in divisions	
	More complainants opting for and receiving a Local Resolution Meeting as opposed to formal written response	Inability of doctors to attend meetings due to clinical commitments	Meetings scheduled to take account of commitments by providing at least 4 weeks' notice
		Doctors do not feel supported to respond appropriately to complainants	Communication training for Doctors together with direct support from Divisional Director
	Localised learning, particularly on wards and within specialties	Learning from complaints not shared trust wide.	Themes from complaints reported to Trust Board and Divisional Governance

			meetings.
		Coding of complaints on Datix system is restrictive therefore identifying detail below themes sometimes difficult.	Interim Datix manager and support, upgrading Datix system to enable more detail to be analysed and triangulated with Incidents, claims etc.

The outcomes from the Confirm and Challenge event and other work members have undertaken during IAT visits, walkabouts etc. in addition to the reports it has received either from executive members or independent sources such as Internal Audit or the CQC/Keogh visits for example, provide the evidence required to assure the board of improvements.

In January 2014 the board were informed of the improvements made against each of the QGF questions to return a score of 3.9

Further improvements have been made as evidenced above, particularly in relation to question 3a.

- The Board Development programme has commenced and actions have been identified to improve the skills of the board further.
- An Accountability Framework has been agreed which has improved understanding and awareness of collective and individual responsibilities.
- The substantive Head of Governance will be in post in February 2014 and will drive the restructure of the GSU
- Board sub-committees have been reviewed and Terms of Reference approved to ensure appropriate focus on quality together with improved reporting to Trust Board

In relation to questions 3b, 4a, 4b and 4c improvements are on-going and will be evidenced in future reports to board.

QUALITY GOVERNANCE FRAMEWORK

The Monitor guidance in respect of the Quality Governance framework identifies under each question areas of best practice. These are detailed below, Board members are asked to review the best practice, the evidence detailed above and re-score against each question

Processes and Structure

3A: Are there clear roles and accountabilities in relation to quality governance?

PWC external review score – November 2012 *1.0*
Trust Board Self-Assessment Score – October 2013 *0.4*

PWC external review score – January 2014 *0.5*

Best Practice

3a	Are there clear roles and accountabilities in relation to quality governance?	
	Examples of Good Practice	
	Each and every board member understand their ultimate accountability for quality	
	There is a clear organisation 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)	
	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	
	Quality performance is discussed in more detail each month by a quality focussed board sub-committee with a stable, regular attending membership	

3C: Does the Board actively engage patients, staff and other key stakeholders on quality?

PWC external review score – November 2012 *1.0*
Trust Board Self-Assessment Score – October 2013 *0.4*
PWC external review score – January 2014 *0.5*

Best Practice:

3c	Does the board actively engage patients, staff and other key stakeholders on quality?	
	Examples of Good Practice	
	Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance	
	The board actively engages patients on quality e.g.	
	Patient feedback is actively solicited, made easy to give and based on validated tools	
	Patient views are proactively sought during the design of new pathways and processes	
	All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board	
	The board regularly reviews and interrogates complaints and serious untoward incident data	
	The board uses a range of approaches to 'bring patients into the board room' (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing)	
	The board actively engages staff on quality e.g.	
	Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly 'temperature gauge' plus annual staff survey)	
	All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the board	
	The board actively engages all other key stakeholders on quality e.g.	
	Quality performance is clearly communicated to commissioners to enable them to make educated decisions	
	Feedback from PALS and Health Watch is considered	
	For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway	
	The board is clear about Governors' involvement in quality governance	

Measurement

4A: Is appropriate quality information being analysed and challenged?

PWC external review score – November 2012 *1.0*

Trust Board Self-Assessment Score – October 2013 *0.3*
PWC external review score – January 2014 *0.5*

Good Practice:

4a	Is appropriate quality information being analysed and challenged?	
	Examples of Good Practice	
	The board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include:	
	Key relevant national priority indicators and regulatory requirements	
	Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3)	
	Selected 'advance warning' indicators	
	Adverse event report/serious untoward incident reports/patterns of complaints	
	Measures of instances of harm (e.g. Global Trigger Tool)	
	Monitor's risk ratings (with risks to future scores highlighted)	
	Where possible/appropriate, percentage compliance to agreed best-practice pathways	
	Qualitative descriptions and commentary to back up quantitive information	
	The board is able to justify the selected metrics as being:	
	Linked to the trust's overall strategy and priorities	
	Covering all of the trust's major focus areas	
	The best available ones to use	
	Useful to review	
	The board dashboard is backed up by a 'pyramid' of the more granular reports reviewed by sub-committees, divisional leads and individual service lines	
	Quality information is analysed and challenged at the individual consultant level.	
	The board dashboard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the board commits time and resources to developing new metrics	

4B: Is the Board assured of the robustness of the quality information?

PWC external review score – November 2012 *4.0*
Trust Board Self-Assessment Score – October 2013 *0.5*
PWC external review score – January 2014 *0.5*

Best Practice

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	

4C: Is quality information used effectively?

PWC external review score – November 2012 *1.0*

Trust Board Self-Assessment Score – October 2013 *0.3*
PWC external review score – January 2014 *0.5*

Best Practice

4c	Is quality information being used effectively?	
	Examples of Good Practice	
	Information in quality reports is displayed clearly and consistently	
	Information is compared with target levels of performance (in conjunction with RAG rating), historic own performance and external benchmarks (where available and helpful)	
	Information being reviewed must be the most recent available and recent enough to be relevant	
	On demand' data is available for the highest priority metrics	
	Information is 'humanised'/personalised where possible (e.g unexpected deaths shown as an absolute number, not embedded in a mortality rate)	
	Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance	

RECOMMENDATION

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