

Board of Directors Meeting

Report

Subject: QUALITY GOVERNANCE FRAMEWORK

Date: 25th SEPTEMBER 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.

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 executive leads will scrutinise 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

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

RECOMMENDATION

1. 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

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BACKGROUND

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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	Sept 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
<p>April 2014 update</p> <p>The Patient Safety and Quality Strategy which identifies the quality priorities for the Trust was approved by Trust Board in March 2014.</p> <p>‘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.</p> <p>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.</p>							
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
<p>April Update</p> <p>The Board receives updates of the Board Assurance Framework at each meeting.</p> <p>The Audit and Assurance board sub-committee also reviews and escalates where appropriate relevant risks from the corporate risk register.</p> <p>The monthly and quarterly quality reports presented to board detail, complaints, incidents, claims and serious incidents identifying themes and the potential impact on quality.</p> <p>May Update</p> <p>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.</p> <p>June Update</p> <p>The Board Assurance statement is submitted to the Trust Board twice a year, in March and September.</p> <p>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.</p> <p>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.</p> <p>The Board Assurance Framework and Corporate Risk Register will have started to go through the</p>							

<p>new process before the production of the September Board Assurance Statement in September 2014.</p> <p>July Update</p> <p>Enhancing focus of quality and performance reports with regard to exceptions requiring more expedient action/decision.</p> <p>Further work with Newcastle to understand and learn from good practice with regard to the reporting of quality and risk</p> <p>Clarity regarding Board Development sessions in Q3 regarding the link to clinical and quality governance and the risks</p> <p>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</p> <p>September update</p> <p>Reinvigorated Board Assurance Reporting process to inform the Board Assurance Framework submitted to Audit Committee for approval.</p> <p>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.</p>							
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
<p>April Update</p> <p>All board sub-committees are chaired by and have NED representation.</p> <p>Monthly quality reports and quarterly patient experience reports identify themes and learning from complaints and incidents.</p> <p>‘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.</p> <p>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.</p> <p>All board members take part in internal assurance visits to wards and other clinical areas.</p> <p>Board development Programme began on 23rd January, facilitated by Foresight Partnership (authors</p>							

<p>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</p> <p>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.</p> <p>May Update</p> <p>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.</p> <p>June Update</p> <p>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.</p> <p>A board effectiveness review which is scheduled in Q3 will be undertaken by Foresight.</p> <p>July Update</p> <p>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</p> <p>September Update</p> <p>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</p>							
2b	Does the board promote a quality-focused culture throughout the Trust?	1.0	0.4	0.0	0.0	Jan 2014	K Fisher
<p>April Update</p> <p>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.</p> <p>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</p>							

	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
<p>April and May Update</p> <p>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.</p> <p>The Executive team have developed and agreed an accountability matrix.</p> <p>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.</p> <p>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.</p> <p>The substantive Medical Director will be full time with the Trust from June 2014</p> <p>June Update</p> <p>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</p>							
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
<p>April Update</p> <p>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.</p> <p>Investment in Datix system will enable richer reporting of information</p> <p>Clinical audit and effectiveness group was launched 16th April 2014 with a strengthened focus on clinical audits.</p> <p>Strengthened focus on 'fitness to practice' performance management approach.</p> <p>May Update</p> <p>SUI process approved at TMB on 22nd April and Quality Committee were assured at their meeting on</p>							

<p>22nd regarding the revised process. The committee has requested an update on the process in 3 months' time.</p> <p>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</p> <p>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.</p> <p>June Update</p> <p>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.</p> <p>The Serious Incident reporting process has been revised.</p> <p>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</p> <p>July Update</p> <p>The revised Serious Incident reporting process, the structure of the GSU once all vacancies filled will ensure this standard is met.</p> <p>September Update</p> <p>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.</p>							
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
<p>April update</p> <p>Patient Safety and Quality Strategy developed through outputs from 'In Your Shoes' patient engagement events, approved by Trust Board March 2014</p> <p>Quality priorities for 2014/15 developed through engagement via 'Quality for All'.</p> <p>Director of Nursing and CEO met with Healthwatch and agreed to develop a closer relationship, Healthwatch representative invited to attend Patient Experience Committee.</p>							
4a	Is appropriate quality information being analysed and challenged?	1.0	0.3	0.5	0.5	Nov 14	J Tufnell
<p>April – July update</p>							

<p>Monthly Integrated Performance Report includes data and information on Monitor Risk Assessment Framework standards, Quality and Safety and Patient Experience.</p> <p>Quality data reports are submitted to board sub-committees chaired by NEDs prior to submission to the Board.</p> <p>Quality information is challenged through the divisional clinical governance process, however further work is required to fully embed and sustain the ward to board flow of information.</p> <p>The Trust need to develop a process of producing quality information at consultant level</p> <p>September update</p> <p>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.</p>							
4b	Is the board assured of the robustness of the quality information?	4.0	0.5	0.5	0.5	Sept 14	J Tufnell
<p>April – July update</p> <p>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.</p> <p>A data quality ‘kite mark’ is currently being developed to RAG rate the quality of the data presented.</p> <p>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</p> <p>September update</p> <p>It has been agreed that the Monitor Risk Assurance Indicators will be used as part of the data quality cycle.</p> <p>During August and September the first indicators across six areas have been reviewed utilising the DQ kite Mark approach.</p> <p>The six areas include:</p> <ul style="list-style-type: none"> • 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 <p>The Trust has commenced work with Nottingham University Hospitals who use the same Patient</p>							

	<p>Administrative System (PAS), in order to ensure that from October 2014 onwards report replication or organisation specific amendments will be more easily produced.</p> <p>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</p>						
4c	Is quality information being used effectively?	1.0	0.3	0.5	0.5	March 2015	S Bowler
<p>April – July update</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Performance is reported the month following achievement i.e. February performance is reported in March.</p> <p>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.</p> <p>Falls deep dive information was presented to the Quality Committee and HSMR is reported on a monthly basis validated externally on a quarterly basis.</p> <p>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.</p> <p>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.</p> <p>September update</p> <p>Positive feedback from Quality Committee in relation to quality of reports and presentations.</p> <p>Culture of deep dives, within governance to understand root cause</p> <p>Serious Incident process is strong and challenging</p> <p>Greater understanding of learning opportunities as sub committees</p> <p>Early warning dashboard being updated to reflect current quality and operational challenges</p>							

RECOMMENDATION

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