Sherwood Forest Hospitals NHS
NHS Foundation Trust

**Agenda Item:**

# Board of Directors Meeting Report

**Subject:** Care Quality Commission (CQC)
**Date:** Thursday 30th January 2014
**Author:** Susan Bowler
**Lead Director:** Susan Bowler – Executive Director of Nursing & Quality

**Executive Summary**

The CQC inspection of the Trust in June (26th) and July (8th, 9th, 10th, 17th, 18th) 2013 resulted in five compliance judgements, of which one indicated a 'warning notice' in respect of Outcome 16, *assessing and monitoring of the quality of service provision.*

The Trust received a CQC follow up visit on the same day as the Keogh follow up. This CQC visit **only** assessed the warning notice and future visits are anticipated to assess the Trust's compliance against the other 4 standards which were not previously met.

The formal report was published on the CQC website on 3rd January 2014
http://www.cqc.org.uk/sites/default/files/media/reports/RK5BC_Kings_Mill_Hospital_INS1-1085602472_Responsive_-_Follow_Up_03-01-2014.pdf

The CQC felt that sufficient improvements had been made to enable the warning notice to be reduced to a compliance action

The Trust has submitted an updated set of actions to the CQC. These actions have been incorporated into the Trust improvement plan, monitored by the PMO.

The Trust is preparing for a re-inspection around the new system and are currently developing a peer review process to assess progress and obtain its own assurance against the actions being progressed

**Recommendation**
To note the Trust's current CQC position in relation to the warning notice

To acknowledge the substantial amount of work staff have embraced to improve quality and safety throughout the organisation,

To support the next steps and actions, which will be monitored by the PMO and progressed through the Quality Improvement Group.

| **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 | |

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|---|---|
| **Links to the BAF and Corporate Risk Register** | BAF 1.3, 2.1, 2.2 2.3, 5.3, 5.5 |

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| **Details of additional risks associated with this paper** *(may include CQC Essential Standards, NHSLA, NHS Constitution)* | Failure to meet the Monitor regulatory requirements for governance - remain in significant breach.<br>Risk of being assessed as non-compliant against the CQC essential standards of Quality and Safety. This will change when Fundamental Standards of Care are published. |
| **Links to NHS Constitution** | Principle 2, 3, 4 & 7 |
| **Financial Implications/Impact** | Implications in relation to the staffing outcome >£4 Million |
| **Legal Implications/Impact** | Reputational implications of delivering sub-standard safety and care.<br>Risk of civil and/or criminal action if further compliance issues are noted. |
| **Partnership working & Public Engagement Implications/Impact** | This paper will be shared with the CCG Performance and Quality Group as requested. |
| **Committees/groups where this item has been presented before** | Executive team, PMO, Quality Improvement Group and CMT |
| **Monitoring and Review** | The CQC warning notice has being monitored through the Board of Directors. The delivery action plan is being monitored weekly at the operational working group and monthly at the PMO |
| **Is a QIA required/been completed? If yes provide brief details** | No |

Sherwood Forest Hospitals NHS
NHS Foundation Trust

**TRUST BOARD OF DIRECTORS – JANUARY 29TH 2014**

**CARE QUALITY COMMISSION (CQC)**

## 1. Introduction

The July 2013 CQC inspection resulted in five compliance judgements, of which one indicated a 'warning notice' in respect of Outcome 16, *assessing and monitoring of the quality of service provision.* The table below sets out the judgment the Trust received for the outcomes assessed.

## 2.0 Summary of the CQC findings

| Standard 'Outcome' | Judgement |
|---|---|
| Care and Welfare of people who use the service | Minor impact to patients |
| Meeting Nutritional needs | Moderate impact to patients |
| Cooperating with other providers | Standard met |
| Cleanliness and infection control | Standard met |
| Staffing | Moderate impact to patients |
| Supporting Workers | Standard met |
| Assessing and monitoring the quality of service provision | Moderate impact '**Enforcement Action'** A 'warning notice' was issued with a specific deadline for meeting the standard by the 31st October 2013 |
| Complaints | Moderate impact to patients |

The judgements were issued to the Trust in September 2013 in a CQC formal report, with a separate issue of a 'warning notice'.

The Trust was revisited on 4th December 2013 to assess the Trusts position against the warning notice. The formal report was published on the CQC website on 3rd January 2014 http://www.cqc.org.uk/sites/default/files/media/reports/RK5BC_Kings_Mill_Hospital_INS1-1085602472_Responsive_-_Follow_Up_03-01-2014.pdf

Like the Keogh follow up visit, the CQC saw evidence of demonstrable improvements, but acknowledged that in some areas more time was required to embed or audit against compliance.

## 3.0 New Judgement

The CQC felt that sufficient improvements had been made to enable the warning notice to be reduced to a compliance action. *Note: the CQC only formally assessed Outcome 16 'Assessing and monitoring the quality of service provision'.* The judgements against the other 4 non compliant outcomes remain unchanged.

## 4.0 Going forward

The Trust has submitted an updated set of actions to the CQC (Appendix 1). These have been incorporated into our improvement plan which is being implemented by the corporate teams and the divisions and monitored through the PMO. The CQC acknowledged that the Trust had already progressed most of the required actions and therefore did not require an extensive, new improvement plan.

The CQC has re-designed its collation of evidence and data streams in regards to preparing for inspections. The 'new wave' is developing its systems to have Key Lines of Enquiry (KLOE's) that are both meaningful to inspectors and those that are inspected. The CQC is likely to reassess the Trust against the new fundamental standards;' are they (Trusts) safe, are they effective, are they caring, are they well led and are they responsive to people's needs?' We are preparing for a re-inspection around the new system and are currently developing a peer review process which will involve the Board and senior managers frequently visiting clinical and non clinical environments to obtain their own assurance prior to a re inspection. The Board will receive regular updates of progress against our CQC actions

**Susan Bowler**

Executive Director of Nursing and Quality

| Judgment | Reasons for CQC Judgment |
|---|---|
| Minor Impact | The provider had newly introduced systems to regularly assess and monitor the quality of services but these had yet to prove effective and become embedded in the organisation |

| Action No. | Action Plan | Trust Lead | SFHFT Response Action |
|---|---|---|---|
| CQC1 | External review to scope the current radiology service and staffing requirements. Monthly monitoring of current radiology systems | Director of Operations | All actions are being addressed and progressed through the Quality Improvement Consolidated Action plan which also includes actions from other external reviews – PwC and Keogh Assurance visit. To ensure the organisation takes an holistic approach to embedding and sustaining quality improvements across the organisation |
| CQC2 | Review governors and Board members objectives to ensure they reflect the values and behaviours expected from the Trust | CEO | |
| CQC3 | Continue to strengthen Divisional clinical governance activities and sustain the risk management training programme to ensure a risk management culture is embedded across the Trust | Director of Nursing / Medical Director | |
| CQC4 | Patient experience and engagement strategy to be presented to Trust Board in January 2014 | Director of Nursing | |
| CQC5 | Implement Patient Communication Strategy | Director of Nursing | |
| CQC6 | CEO and Chairman to be more visible to Junior Doctors | CEO | |
| CQC7 | Improve communication with 'all staff group' and more junior staff regarding service developments and recruitment strategies | Divisional Teams led by DCD | |
| CQC8 | Ward level communication in respect of 'Knowing how we are doing boards' to be embedded across the Trust. | Director of Nursing | |
| CQC9 | Ensure all emergency equipment including resuscitation equipment checked and records updated | Divisional Teams led by Divisional Matron | |
| CQC10 | Complaints policy being rewritten to align the revised complaints process and workforce restructure | Director of Nursing | |
| CQC11 | Re-launch complaints and PALS process – once new process and policy implemented | Director of Nursing | |
| CQC12 | Ensure wards/departments respond to PALS monthly reporting process | Director of Nursing | |
| CQC13 | Patient Information Packs to be on each bedside | Director of Nursing | |
| CQC14 | Review cleaning check lists for gaps in records and address | Divisional Teams led by Divisional Matron | |

Sherwood Forest Hospitals NHS
NHS Foundation Trust

# Board of Directors Meeting

**Subject:** **Keogh Update**
**Date:** **Thursday 30 January 2014**
**Author:** **Paul O'Connor**
**Lead Director:** **Paul O'Connor**

| **Executive Summary** |
|---|
| This report provides an update on progress against the Keogh Action Plan |
| **Recommendation** |
| The Board is asked to note the content of this paper |

| **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** | |

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| **Links to the BAF and Corporate Risk Register** | Numerous, given the wide range of the Keogh Action Plan |
| **Details of additional risks associated with this paper** *(may include CQC Essential Standards, NHSLA, NHS Constitution)* | N/A |
| **Links to NHS Constitution** | N/A |
| **Financial Implications/Impact** | Dependent upon final Board decisions on additional nursing resulting from the Action Plan |
| **Legal Implications/Impact** | N/A |
| **Partnership working & Public Engagement Implications/Impact** | Significant reputational risk if the Trust does not emerge from Special Measures |
| **Committees/groups where this item has been presented before** | N/A |
| **Monitoring and Review** | See Appendix 1 |
| **Is a QIA required/been completed? If yes provide brief details** | N/A |

**Keogh Update**

In its December Public Board meeting, the Board received details of the informal feedback received from Dr David Levy following the re-visit of a subset of the original Keogh Rapid Response Review Team on 4th December 2013. The Trust has subsequently received the completed final report which has been shared with Monitor. A copy of this report with Dr Levy's covering letter is included at Appendix A.

Dr Levy's report clearly identified that much good work has taken place. He says " . . it is clear that the Trust's culture and the mood has shifted to a much more positive place to be cared in . You and your team should feel proud of what you have achieved, in such a short period of time. I am confident that you will continue to provide the best possible care to the patients that you treat".

In the report, Dr Levy identified 6 actions which are "assured" and a further 17 actions which are "partly assured", with no areas "not assured". The partly assured elements of the action Plan are seen to require more time to ensure that they are fully embedded or audited against compliance.

I believe the Trust is making good progress against all elements of its Keogh Action Plan. We are keeping our staff, the public, and stakeholder organisations aware of our progress, and we performance manage maintaining the momentum within a weekly project management process that brings together the required deliverables against Keogh, CQC and PWC Governance Action Plans. The Trust will remain in Special Measures until the CQC's formal assessment later this year, the date of which is not yet known. It is thought unlikely that any Trust will emerge out of Special Measures until all of the Special Measures Trusts have been formally reassessed by the CQC.

The Trust has shared a draft proposal for "buddying" arrangements with The Newcastle Upon Tyne NHS Foundation Trust.

The purpose of the buddying agreement is to further improve the quality of services and governance at the Trust. A workplan has been proposed which identified 4 key programmes for improvement as follows:

1. Delivery of Integrated Improvement Programme;
2. Enhancing relationships with Primary Care to deliver vertically integrated patient pathways;
3. Business Intelligence & Analysis;
4. Improved Trust Board Quality Governance Score.

The agreement between ourselves, our buddying partner and Monitor will involve payment to the Buddying Trust by Monitor and is currently subject to negotiation which is hoped to be completed by the end of January 2014. I will give a further verbal update at the Board meeting.

**Paul O'Connor**

**Chief Executive**

**Our Ref**: DL/FM/Sherwood

NHS England
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB1 5XB
Email address: dlevy1@nhs.net
Telephone Number: 011382 53172

FAO:
Paul O Connor, CEO
Sean Lyons, Chair
Sherwood Forest Hospitals NHS Foundation Trust

**BY EMAIL ONLY:**
**Paul.O'Connor@sfh-tr.nhs.uk**
**sean.lyons@sfh-tr.nhs.uk**

27 January 2014

Dear Paul and Sean

**Visit to Sherwood Forest Hospitals NHS Foundation Trust on behalf of Monitor**

Thank you very much for the kind hospitality and welcome given to myself and the team when we revisited on the 4th December 2013. Please find attached the completed final report which we will share with Monitor.

We reviewed the outcomes from the huge amount of work you and your team have undertaken in the last 6 months, since the Keogh visit. We saw many examples of good team working and progress against the action plan.

Our brief was to look at outcomes of the actions taken per the action plan. This is a step beyond simple assessment of action being undertaken. In some areas we were fully assured that we could see evidence of demonstrable and sustainable improvement. In other areas we have marked partial assurance, as we considered some more time was needed to embed or audit against compliance.

I do want to share the team's view of how different the Trusts culture and mood felt as we moved around the hospital, and from speaking to both staff and patients. It is clear that the Trust's culture and the mood has shifted to a much more positive place to be cared in.

You and your team should feel very proud of what you have achieved, in such a short period of time. I am confident that you will continue to provide the best possible care to the patients that you treat.

If you would like to discuss any issues arising from the report please do not hesitate to contact me.

Yours sincerely

Dr David Levy
Medical Director – NHS England Midlands and East

# Assurance review to Sherwood Forest Hospitals NHS Foundation Trust

**Prepared by NHS England, Midlands and East region, on behalf of Monitor**

**January 2014**

## Contents

## Introduction

Sherwood Forest Hospitals NHS Foundation Trust was one of 14 NHS hospitals inspected as part of Sir Bruce Keogh review of the quality of care and treatment in June 2013. As part of that review, a multi-agency risk summit was held to agree an action plan. It was agreed at the risk summit that a follow-up visit would be held later in the year to review progress. Following the Keogh review, the trust was put under 'special measures' by Monitor on 16 July 2013. Monitor has appointed a Improvement Director Mike Shewan to oversee the improvement plan.

## Purpose of the assurance review

Responsibility for monitoring progress against the agreed action plan rests with Monitor as the regulator of NHS Foundation Trusts. Monitor subsequently requested support from NHS England in carrying out that review visit. The review terms of reference agreed between Monitor and NHS England are attached at appendix 1.

NHS England's support has comprised of:

- A desktop review of the documentary evidence supplied by the trust in support of its progress against the agreed action plan
- A one day announced site visit, undertaken by a multi-agency panel of experts, to look at whether behaviours and activity on site at the hospital was in line with the documentary evidence received, and to ascertain to what extent the agreed actions had been implemented or were effective. This included meetings with members of the trust board, talking to patients, carers and staff, and undertaking ward and departmental visits
- Preliminary feedback to be provided to the Trust at the end of the review, and shared with Monitor and CQC
- Panel to escalate any concerns whilst on site to the CQC, Monitor, CCG, and trust for action
- A formal report on the panel's findings

The assurance review panel was chaired by Dr David Levy, Regional Medical Director for NHS England (Midlands & East) who chaired the initial Keogh visit. The panel included a number of the original Keogh panellists, including the lay representative, and representatives of NHS Newark and Sherwood Clinical Commissioning Group and NHS England's area team for Derbyshire and Nottinghamshire. This one day assurance visit was intended solely to review progress against the action plan and was not intended to identify any new areas of concern or make recommendations about the removal of special measures in place.

## Methods of investigation

A one day desk top review was undertaken by NHS England and a one day announced visit followed this at Sherwood Forest Hospitals NHS Foundation Trust on Wednesday 4 December 2013. The panel visiting the trust consisted largely of the members of the Keogh review panel, allowing comparisons to be made over time. As the Keogh review visit, the panel used a variety of methods including interviews, focus groups, ward observations and review of documentation. This has enabled the panel to consider evidence from multiple sources in making their judgments.

## Summary findings

Following review of evidence from available sources, the panel agreed whether they are 'assured', 'partly assured' or 'not assured' that the trust has implemented the actions agreed following the Keogh quality of care and treatment review.

Where it was agreed that the trust had fully implemented an action and the outcomes of that action were apparent, an outcome of 'assured' was recorded. Where there was evidence of progress with implementation, but implementation was not complete, the outcomes were not yet evident or it was too early to tell if the changes were embedded and sustainable, the panel recorded an outcome of 'partly assured'. Where there was no evidence that implementation had started, or significant concerns remained, the panel was able to record an outcome of 'not assured'.

An outcome has been recorded for each group of actions set out in the reports of the Keogh rapid responsive review and risk summit.

In summary, 23 groups of actions were assessed, with 6 recorded as 'assured' and 17 as 'partly assured'. No areas were recorded as 'not assured'. The outcomes in summary are listed below:

1. Complaints and support staff – partly assured
2. Nursing and medical staffing levels and nurse skill mix – partly assured
3. Fluid management – partly assured
4. Strategic direction – partly assured
5. Newark hospital strategy, facilities and governance – assured
6. Board development and development of a quality focus at Board level – partly assured
7. Ward performance information and organisational learning – partly assured

8. Patient locations and patient moves – partly assured
9. Handovers – partly assured
10. Patient experience – partly assured
11. NEWS roll out – partly assured
12. Whistleblowing policy – assured
13. Supporting structures and services – partly assured
14. Anaesthetists – partly assured
15. Staff development – assured
16. Communication with patients – partly assured
17. Ability to rescue – partly assured
18. Maintaining the pace of change – partly assured
19. Governors – assured
20. Organisational learning – partly assured
21. A&E – assured
22. Medicines management – partly assured
23. Infection control - assured

**Key findings of the assurance review**

| Keogh review action | Outcome:<br>• Assured<br>• Partly assured<br>• Not assured | Comments including any outstanding issue(s) |
|---|---|---|
| **Urgent actions** | | |
| **1. Complaints and support staff levels** | | |
| 1.1 The backlog of complaints to be cleared, under the director of nursing's leadership.<br><br>1.2 Redesign the complaints process, including:<br>• Involving patients in the redesign<br>• Appropriate resource for the process<br>• Integration of Patient Advice and Liaison Service (PALS) and complaints<br>• A revised process that engages consultants<br><br>1.3 Reports on complaints and incidents to the Board should detail themes and actions being taken. Complaints can be triangulated through the use of patient stories at the Board.<br><br>1.4 Support staff levels and roles to be reviewed and sustainable plans to be put in place for managing complaints, discharge letters, clinic appointments and radiology reporting. | Partly assured | The complaints backlog has been cleared.<br><br>Short and medium term changes have been made to the complaints process. Complaints are devolved to the teams where they originate, and are being managed through the divisional structure. Complaints are influencing staff appraisals, and reflectional complaints are evidenced on ward dashboards. Staff attitudes are being challenged, and escalated where necessary. An agenda has been devised for the Board to include complaints.<br><br>The trust recognises the longer-term changes required, including structural changes and further work on ensuring lessons are learned and shared following complaints. The complaints policy will be updated once further changes have been made.<br><br>An interim complaints manager is in post, and a new Head of Governance has been appointed, starting in the New Year. The trust is beginning consultation with staff regarding the future complaints and PALS structure. |

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| **2. Nursing and medical staffing levels and nurse skill mix** | | |
| 2.1 Trust to identify acceptable nursing levels for each ward and the director of nursing should provide immediate assurance that these levels are being met out of hours and that there is appropriate supervision in place for untrained staff.<br><br>2.2 Intentional rounding to be implemented across the trust<br><br>2.3 (CCG action)<br><br>2.4 Nursing staffing and establishment review with recommendations for issues identified. King's Mill Hospital should consider the patients on the wards, benchmarking with other Private Finance Initiative (PFI) hospitals. Both reviews should account for staff sickness, with particular review at Newark Hospital with the lower levels of staffing there. The review should include understanding of workforce in relation to performance, for example are workforce levels impacting on mortality or patient falls and safety<br><br>2.5 A workforce strategy should be developed as a result and this should include policies on appropriate use of agency and locum staff ensuring that they are not putting the hospital at risk. This should also include adequate support for junior staff. The Trust to consider expanding the role of Health Care Assistants to train them formally to provide more of a support role to nurses. | Partly assured | The panel recognised good improvement against this action, although there remain real challenges for the trust to address. Each ward now displays how many staff on duty and the ratio of qualified staff to patients clearly displayed.<br><br>Nurse staffing levels have improved, including overnight. We heard that increased night staffing was making a positive impact on workload, for example non-food associated drug rounds on one ward were being completed before the handover to day staff. The director of nursing has completed a nursing staffing review, and presented the outcomes to the board; however, actions have not yet been agreed. She proposed that £4m investment is required in nurse staffing, and was asked by the board to demonstrate more clearly the benefits and return on investment. She will present a further paper to the December board. We raised our concerns with the chief executive about the delay in agreeing actions and investment following this review.<br><br>Ward leaders have been well engaged in the process; they felt supported and part of the leadership. However, this has not consistently filtered beyond ward leaders and more junior staff do not yet feel fully engaged.<br><br>Outside of nursing, there has been less progress on |

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| 2.6 A review of the nursing skill mix with immediate plans to ensure that the skill mix in place is adequate to provide safe patient care. To utilise national and professional benchmarks to determine appropriate levels, also taking account of the facilities and environment at each hospital.<br><br>2.7 (NHS England action) | | staffing levels. The all staff focus group told us that they had not seen any change, and felt additional staff were needed in other areas, particularly healthcare assistants. The junior doctor focus group told us that there had been an effort to increase middle grade and consultant support, but that this has not kept pace with increases in patient numbers and workload. They noted that pressure was increased by the inexperience of F1 and F2 doctors due to F1s not working out of hours, and limited use of advanced nurse practitioners (ANPs). We heard from the head of nursing for emergency care that the emergency department is making better use of emergency nurse practitioners and that ANPs are being piloted in other areas.<br><br>There remain real difficulties in recruiting both medical and nursing staff and shifts are often made up with bank, agency and locum staff. Junior doctors advised that recruitment difficulties affected deanery training posts, which are not being filled and are being covered by locums of variable quality.<br><br>We understood that there can be significant delays in HR process, meaning that candidates offered posts do not always take them up as they find other posts in the meantime, and that new staff do not always stay for the duration of the 6 week induction. Preceptorship programmes seem to be inconsistent across the Trust. |
| **3. Fluid management** | | |
| 3.1 Actions to improve fluid management to be | Partly assured | The trust has introduced hydration charts and fluid |

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| implemented, including:<br>• Training through induction / development days to strengthen nutrition and hydration<br>• Protected mealtimes, red tray and red jug policy to be revised and relaunched<br>• Communications campaign on fluid management and red jug scheme<br><br>3.2 Assurance model implemented that is fit for purpose to provide evidence that actions are improving fluid management<br><br>3.3 (NHS England action) | | balance charts in all patient notes, with a risk matrix indicating which should be used. We saw that these were being completed by staff, and some wards really appreciated them. There is further work to ensure these are being used actively and are embedded. We saw two examples where charts had been completed, but the individuals were still not receiving sufficient fluids, i.e. 200-250ml at noon.<br><br>The fluid balance charts introduced do not allow an easy view of a 24 hour period, and therefore of fluid balance over a number of days. Staff on the surgical wards did not feel the charts met their needs and were therefore not using them. We recognise that the charts have only recently been introduced and are to be reviewed; we'd recommend that these issues be considered as part of that review. |
| **4. Strategic direction** | | |
| 4.1 Clinical strategy to be developed and submitted to Monitor based on clear commissioning intentions within the Mid Nottinghamshire Review agreed framework.<br><br>4.2 (NHS England area team action)<br><br>4.3 Nursing strategy to be published<br><br>4.4 Supporting strategies to be reviewed and updated to be aligned to the clinical strategy. These are to include IT, estates, communications, research and innovation, workforce and organisational development strategies.<br><br>4.5 (Nottingham University Hospitals action) | Partly assured | The panel felt good progress had been made against this action. While we gave the action urgent priority following our review in June, we recognise that it requires significant work and consultation.<br><br>A draft clinical strategy has been produced for submission to Monitor by 31 October. The next phase of development is to share this with clinicians for service line modelling. It is expected that this work will be ongoing over the next few months, and should be completed by March 2014.<br><br>Supporting strategies are dependent on the clinical strategy being completed. |

| 5. Newark Hospital – strategy, facilities and governance | | |
|---|---|---|
| 5.1 Newark strategy to be developed through stakeholder event organised for 24 July 2013, to include communication and engagement strategies.<br><br>5.2 Review of staffing arrangements and Newark Hospital including anaesthetists review<br><br>5.3 Cover arrangements implemented to ensure that, even in the case of sickness, there is doctor cover at Newark overnight every night<br><br>5.4 Review of medical arrangements at Newark to consider adequacy. To include review of day and out of hours cover. To include change of consultant round timings to provide consultant rounds five days a week. Review to cover surgery, procedures and MIU.<br><br>5.5 (NHS England action)<br><br>5.6 Immediate review as to whether the facilities at Newark have detrimentally impacted on patient safety over the last six months.<br><br>5.7 Agreement of required action plan arising from the results of the review with NHS England regional medical director<br><br>5.8 Review governance arrangements at Newark hospital as part of the trust governance action plan to ensure that management arrangements and reporting structures are robust. | Assured | A Newark strategy has been developed and signed off. The trust is now engaging with the public and patients about it.<br><br>The director of operations is the executive lead for Newark, and is present and visible at Newark on regular basis. A deputy director of operations has been recruited and due to start in January 2014; they will be based 2 days a week from Newark. We heard from the Newark site manager that other board members have also been visible on site, including drop in sessions with the chief executive, which have been well received by staff.<br><br>There is a physician on site daily Monday-Friday, and out of hours arrangements have also been reviewed and improved.<br><br>The CCG carried out a review, and found that the facilities at Newark have not detrimentally impacted on patient safety over the last six months.<br><br>We heard that Newark hospital is now its own division, with separate governance structures which has been welcomed by staff.<br><br>We understand that the trust will imminently confirm the surgical procedures that will continue to be undertaken on the Newark site. [N.B. this action should move to partly assured if list is not confirmed, or is inappropriate/not in line with review |

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| 5.9 (CCG action)<br><br>5.10 The choice of surgical procedures being undertaken would be reviewed by an independent surgeon. Panel with ask head of surgery from regional hospital to come and examine the safety of issue around identification of safe surgeries. | | recommendations.] |
| **6. Board development and development of a quality focus at Board level** | | |
| 6.1 Comprehensive development programme for the board<br><br>6.2 Quality strategy to be developed including assurance framework and implementation plan<br><br>6.3 The current focus on mortality to be widened to consider quality and safety.<br><br>6.4 Sufficient time should continue to be given to quality issues at the Board.<br><br>6.5 Directors responsibilities should be clearly articulated and sufficient time to be given to these.<br><br>6.6 The Board should hear a patient story at every Board meeting<br><br>6.7 Board away day development to develop quality and transformation strategy. Board away day time to review quality governance and align this to annual business planning. | Partly assured | There is evidence of progress on this action; however, the panel felt more pace was needed, particularly on board development.<br><br>The trust has recently tendered for a board development programme, and is reviewing bids against other options. The Chair and Non Executive Directors (NEDs) are relatively new in post and could benefit from some team and quality focus development sessions. This is a potential barrier to real quality focus at the board level.<br><br>An impressive and measurable patient safety and quality strategy has been developed and was taken to the last board to be signed off. The strategy identifies reducing mortality, reducing harm, improving reliability and improving patient experience to make Sherwood Forest one of the safety organisations in the NHS.<br><br>The interim medical director presented recent work on mortality at board level. We were not clear that this was reflected through all the directorate and |

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| 6.8 Improvement trajectories need to be set with a range of KPIs and run charts that underpin the overarching strategy for HSMR reduction<br><br>6.9 On a rotation basis, a member of the Executive team should be regularly based at Newark Hospital and Non Executive Directors and Governors should regularly visit that Hospital.<br><br>6.10 Every Board meeting to include a public session | | divisional structures.<br><br>The roles of the Board and NEDs have been clarified which includes a NED for Newark hospital and plans to link in with Governors as part of this is in place.<br><br>The board is hearing patient stories, and we heard that the chairman also feeds back to board meetings the comments and stories he hears on walkabouts of the trust.<br><br>Board meetings are being held in public and one board meeting has been held off site.<br><br>Trust governance arrangements are not yet fully aligned to the board, and some sub-committee papers are received at board meetings before the sub-committees have had the opportunity to meet and discuss them. |
| **7. Ward performance information and organisational learning** | | |
| 7.1 Ward dashboards to be in place in all wards containing up to date information<br><br>7.2 Process for discussion of results with ward staff at all levels for learning to be agreed with NHS England along with timescales<br><br>7.3 Review of the Trust decision to remove ward white boards<br><br>7.4 A quality strategy to support the completion of | Partly assured | New ward dashboards have been introduced and are in place across the wards. These appear to be both appreciated and used by staff, patients and visitors.<br><br>The panel felt there had been really good progress and engagement in the last month. Further evidence will be required over the coming months that the dashboards, and regular discussion of results with ward staff, have become embedded. |

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| routine triangulated quality reports incorporating patient safety, patient experience and clinical effectiveness<br><br>7.5 A comprehensive patient safety programme to enable staff to understand how process and outcome measures aid the delivery of an HSMR reduction | | See above comments regarding the quality strategy.<br><br>The panel heard that mortality reviews are not consistent across directorates.<br><br>Although the patient safety and quality strategy has been developed, the panel did not feel the patient safety programme was in place as yet, much as there have been a number of initiatives. It was concluded there has been limited progress so far. |
| **8. Concerns over patient locations and high numbers for patient moves** | | |
| 8.1 Bed modelling to ensure correct forecast capacity requirements are identified<br><br>8.2 The trust will ensure that where a patient move is required that a risk assessment is completed prior to the move taking place.<br><br>8.3 Targets to be defined and communicated for ambitions for maximum bed moves and outliers<br><br>8.4 Bed meetings to routinely discuss patient safety concerns and identification of outliers and escalation areas. | Partly assured | The trust provided a draft policy, dated 7 October, which includes requirement for careful consideration of risks prior to making a patient move outside of the primary specialty and a principle commitment to specialty review to the outlying patient.<br><br>In practice, we heard that each ward has a linked outlier ward, where any patients would be admitted when the primary ward is full. Patients on the outlier ward are reviewed routinely as part of the main ward round. Patients are risk assessed on the emergency assessment unit and assigned a category, according to whether they must be admitted to the primary ward or could safely be admitted to another ward. Both medical and nursing staff reported real improvements in-hours on most wards. We heard that the system does not work as well out-of-hours, as the categories may be overruled by the site manager to manage bed pressures. We also heard that it could be difficult to ensure consultant cover for |

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| | | outlying patients on the cardiology ward and from day case as these wards do not have allocated medical consultant cover. We noted that the outlier risk assessment form was not known by some of the front line staff and did not include the named lead consultant for each patient. We recommend that the trust reviews these issues.<br><br>The panel felt that further analysis of the bed base was required. |
| **9. Handovers** | | |
| 9.1 Ward handover arrangements to be reviewed as part of the nursing staffing levels and establishment review (see 2.4)<br><br>9.2 As part of immediate review into staffing levels (2.1), ensure appropriate handover times and that the ward lead has knowledge of all patients on the ward. | Partly assured | The nursing handover process has been revised, and includes bedside handovers for each patient. The changes have been well received. However, the time allowed for nursing has only been increased from 20 minutes to 30 minutes, and it was felt that this remained inadequate. Staff reported that they are still staying late to complete paper and bedside handover and suggested that 45 minutes was required. The Panel heard that staff find the accountable handover sheets extremely useful for effective communications between shifts. As this sheet includes all patients, however, the patient-specific information is not retained in individual patients' notes. It is recommended that the trust considers this issue.<br><br>We heard from junior doctors that an electronic handover process has been introduced in surgery, which is making a positive difference. The system linked to the patient administration system (PAS) and showed the location of the patient; it also |

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| | | included jobs, and allowed these to be added to the out-of-hours list and chased. There is a current project to look at how this could be rolled out in medicine by a patient safety fellow. More staff have been trained up on PAS, but it remains an issue in different directorates out of hours. No junior staff reported having PAS training. |
| **10. Patient experience** | | |
| 10.1 Patient experience and engagement strategy to be written in partnership with staff, patients, carers and governors<br><br>10.2 To be proactive in its approach to engaging with patients and their families and carers.<br><br>10.3 Staff to wear name badges and clearly communicate to patients who their consultant is. Where consultants are changed, the reasons for the change to be communicated patients.<br><br>10.4 Audit times taken for buzzers to be answered and ensure issues identified are rectified.<br><br>10.5 Review staff uniform policy so that patients and the public can easily recognise staff levels by their uniform | Partly assured | Through its "In Your Shoes, In Our Shoes" programme the trust has been very proactive in listening to and engaging patients, staff, carers and governors to identify what matters most to them with respect to patient experience. There is no patient experience strategy is place as yet. However, there is a clearly defined process, which is on track to meet the aim of patient and staff experience strategies going to the trust board in January 2014.<br><br>Each ward now displays in a consistent visual format clear information which is useful and accessible to patients and carers. The introduction of 'care and comfort rounds' has been welcomed by ward leaders. One said 'Care and Comfort – I really like it'.<br><br>We saw that staff are wearing their security badges, but not name badges and it's not easy to read the names on the security badges. There is better signage and information and visual demonstrating uniform colours on the wards about the staff on duty and about the consultant responsible for each patient. |

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| | | Although there is no NED named as lead for patient experience this was a conscious decision by the Chair as it was felt all the Board members had a responsibility. |
| **11. National Early Warning Score (NEWS) roll out** | | |
| 11.1 Revised observation and early warning policy to be published in August 2013 and disseminated to all staff, ensuring that staff and Newark hospital are also aware of the revised policy<br><br>11.2 Training to support the revised policy to be delivered to all relevant staff, including those at Newark hospital<br><br>11.3 Audit process implemented to ensure every ward is compliant with the policy | Partly assured | NEWS has been rolled out across the wards. We heard from some staff and wards that it is appreciated. Staff on the surgical wards are less happy with the tool, because it doesn't include fluid management.<br><br>We heard that healthcare support worker training had had a significant positive impact on adherence to early stages of NEWS cascade. We felt further support and embedding was needed for the later stages. We saw examples in notes of significant NEWS triggers, where evidence of the nursing or medical actions taken was not clearly recorded. During their hours of operation, the critical care outreach team (CCOT) provides the default response to NEWS triggers and we heard there had been a 20% increase in calls to CCOT since NEWS was introduced. We also heard from junior doctors that they receive a large volume of calls for NEWS triggers out-of-hours. They felt that some of these do not require escalation and could be better managed by nursing staff, or could be prevented through review and resetting of triggers in-hours.<br><br>The trust is auditing 290 patients per month for NEWS policy adherence. The audit includes |

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| | | observation completeness, prescription of observation frequency, accuracy of NEWS calculation and calls to a doctor and it looks at activity in-hours. We felt the audit needed to be extended to include medical actions, including any escalation or resetting of triggers, and night-time activity to be properly comprehensive. Audit outcomes are fed back to the ward, head of nursing, nursing forum and divisional management teams. |
| **12. Whistleblowing policy** | | |
| 12.1 The policy should be reviewed and amended to ensure that staff do not perceive that they will be monitored if they blow the whistle. A revised policy will be submitted to the trust board for approval at the September meeting. The policy should include the date last reviewed and regularly reviewed. | Assured | The whistleblowing policy has been revised, and the revised policy was approved by the board.<br><br>Staff we spoke to in the focus groups and on the wards knew that there was revised guidance in place, but were not all sure what whistleblowing means. Although this suggests further staff engagement may be helpful, the panel was satisfied that the action was completed. |
| **13. Supporting structures and services** | | |
| 13.1 Clear the backlog of radiology reporting<br><br>13.2 Root cause analysis review to identify the causes of the radiology backlog<br><br>13.3 Review the impact of the radiology backlog on patient care and safety<br><br>13.4 Terms of reference for the review to be agreed with commissioners<br><br>13.5 Development of actions to prevent the radiology | Partly assured | The trust has cleared its radiology backlog. Reporting capacity is a continuing issue within the radiology department. The trust reviews the position daily and will outsource activity immediately if any problem, or potential backlog, is identified. Outsourcing has increased recently to maintain reporting times within trust standard.<br><br>The trust is facing some significant challenges with staffing in radiology, which we discussed with the medical director and director of operations. This impacts on capacity, as above, and just under half of |

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| backlog issue reoccurring. This should include clear and explicit standards against which performance should be measured.<br><br>13.6 Similar actions to the radiology reporting to be agreed for discharge letters and clinic appointments<br><br>13.7 Integration of the supporting infrastructure into processes including:<br>• Improved use of IT throughout the trust<br>• Increased clinician engagement in procurement and management of medical equipment across services<br>• Review the linking of buzzers between paired wards<br><br>13.8 Review inappropriate pressures on junior doctors and ensure consent is valid and appropriately informed by procedure-competent or procedure-experienced clinicians. | | consultant radiologist posts are unfilled.<br><br>The trust has redesigned the pathway, which has resulted in 25 additional WTE in the teams overall and some improvements are evident. Administrative support services have also been revised. A formal review of the pathway is being undertaken. The trust also has invited an external review to scope the current radiology service and staffing requirements.<br><br>Junior doctors raised concerns with us about attitudes in the radiology department. We heard that radiologists would not receive requests directly from juniors or report back directly to them. There are no formal agreements in place for medicine or surgery that referrals must be made consultant to consultant, and juniors find the current arrangements frustrating. We recognised that there may need to be some agreement in place to manage referrals while the capacity of the radiology department is under such pressure.<br><br>We heard of improvements planned to IT systems, including a new IT system for PAS to be introduced soon.<br><br>As above, junior doctors continued to report that they are under pressure. They acknowledged that an effort had been made to increase staffing and support, but that this has not kept pace with increases in patient numbers and workload. |
| **High and medium actions** | | |

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| **14. Anaesthetists** | | |
| 14.1 Review anaesthetists' arrangements to formalise their input into pre-operative assessment at both hospital sites and communicate the arrangements to all staff, including:<br>• A named lead for day surgery.<br>• Formal session of time for dedicated preoperative<br>• assessment sessions.<br>• An acute pain clinical session.<br>Use of protocols for preoperative management of comorbidities | Partly Assured | A nurse delivered pre-operative assessment process is in place and anaesthetic input can be obtained if needed. A diabetes management protocol has been placed on the intranet that all staff can consult.<br><br>There is no named lead for day surgery that could be identified by the senior nurse on the day ward. |
| **15. Staff development** | | |
| 15.1 Regular appraisals and personal development plans to be provided to all staff and review of achievement of these by the Board.<br><br>15.2 Trust to introduce staff rotation between King's Mill Hospital and Newark Hospital | Assured | At the trust presentation, we heard about the focus on completing appraisals for all staff. We heard in the focus groups that appraisals have been of good quality. Supported by changes in the complaints process, patient feedback and complaints are informing staff appraisals.<br><br>We did not hear any evidence of staff rotation between King's Mill and Newark hospitals. However, in the light of the revised strategy for Newark, we did not feel that this action remained relevant. |
| **16. Communication with patients** | | |
| 16.1 Patient communication strategy and processes to be developed to ensure patients receive proper and timely communications from presenting within the healthcare system with an illness to resolution of their concern. | Partly assured | As noted above, we saw evidence of improved communication with patients on the wards about the staff caring for them. We also heard that there had been improvements in administrative processes for discharge and clinic letters. However, there is no strategy in place for patient communications. |

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| **17. Ability to rescue** | | |
| 17.1 Do Not Attempt Resuscation (DNAR) forms should be signed by a consultant.<br><br>17.2 Consider updating to comprehensively equipped trolleys | Partly assured | The trust provided evidence of a recent audit showing that 88% of DNAR forms had been signed by a consultant. We reviewed some DNAR forms in patients' notes and found that they were signed by a consultant. The panel was therefore assured on action 17.1.<br><br>On 17.2, we heard that the trust is considering updating its current resuscitation boxes to trolleys, and a business case has been prepared for 75-80 trolleys. The Critical Care Outreach Team (CCOT) and the resuscitation officer felt a key strength in the current system was that used boxes are taken away and replaced with new boxes while the contents are refreshed. They were keen that this was not lost in any new arrangement. We heard that the business case is to be presented shortly, and would expect it to be considered as part of an options appraisal. |
| **18. Maintaining the pace of change** | | |
| 18.1 Early and effective comprehensive induction of new appointments throughout the Trust, including the new Board members supported by effective Board review and development.<br><br>18.2 Systematic Board Governance Assurance Framework and build in discussion regarding the effectiveness of Board at each meeting including whether any new risks have been identified. To be supported by Board development for the Board as a whole and individual Board members. | Partly assured | The panel saw some early evidence that the trust is starting to address this action; however, there is a lot still to do.<br><br>As above, the non-executive director we met advised that there has not been a full induction for new board members. We also heard that new nursing staff do not always stay for the full 6 week induction programme, and that newly qualified staff could not always be released to attend the trust's preceptorship programme. |

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| 18.3 Board engagement as widely as possible with staff groups to both emphasise and energise the importance of the transformation and to engage staff in the changes.<br><br>18.4 Clear and costed training plan to deliver transformation agenda | | The trust shared a draft assessment by PwC against the board governance assurance framework. This demonstrated significant improvement from a similar assessment completed in January. A draft board assurance framework was shared with the board on 3 October, and work is ongoing to finalise it.<br><br>We heard that board members undertake ward walkarounds and internal assurance visits. We also heard that the chairman has worked some ward shifts in support roles, and that particular efforts have been made to improve visibility of board members on the Newark site. Nursing staff reported that the chief executive and chair are visible; however, most junior doctors said they didn't see them and would not recognise them, but would welcome more direct contact with the senior management (they suggested them joining them for lunch one Friday when they all try to get together).<br><br>We did not receive any evidence of a training plan to deliver the transformation agenda. |
| **19. Governors** | | |
| 19.1 The Trust to work with the Governors to transform their role to enable them to support the Trust more effectively and effectively | Assured | The chairman is leading this action, and has undertaken a lot of work to support governors in their roles. He has further work and development planned. We heard there has been good progress, and considered that this action was completed. |
| **20. Organisational learning** | | |
| 20.1 Systems to ensure organisational learning. Adaptation of the resuscitation audits into the deteriorating patient work. Consider linking the | Partly assured | As the complaints section, the trust has made improvements in its process and lessons are being considered in teams and as part of appraisals; this is |

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| resuscitation officer to the outreach team. Organisational development programme in quality improvement leadership and skills linked to patient safety programme. | | also the case for incidents. There is further work to do to ensure that processes and systems are embedded and that lessons are shared across the organisation.<br><br>We heard from the CCOT nurse manager that there had been a decision not to formally link the resuscitation officer and CCOT but that some training was delivered by them jointly.<br><br>The trust is using the global trigger tool for patients admitted unexpectedly to critical care, and all cardiac arrest calls are reviewed in terms of NEWS compliance and for any signs of failure to rescue.<br><br>Staff are listening to patients, including holding focus groups with patients and inviting those patients back in for further feedback. |
| **21. A&E** | | |
| 21.1 Review the A&E triage and observation arrangements to ensure appropriate prioritisation of patients and adequate clinical oversight of the A&E waiting area. | Assured | The trust has reviewed its arrangements for triage and observation of patients in the A&E minors waiting area. It aims to triage patients within 15 minutes. The doors between the waiting room and streaming room are kept open whenever possible to give sight of patients waiting.<br><br>We saw the system in use across A&E to prioritise patients. Processes and patient flow through the department appeared good, and we found the atmosphere calm. |
| **22. Medicines management** | | |

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| 22.1 Medication charts should be clearly completed upon admission to detail existing medication for patients. | Partly assured | We heard that medication and administration are key priorities on the wards. However, we saw medication charts that had not been completed and drugs not prescribed. We heard that To Take Out drugs (TTOs) are an issue, and can be delayed. The trust is considering the implementation of e-prescribing. |
| **23. Infection control** | | |
| 23.1 Review of infection control processes including location to hand gel throughout the Trust. Enforcement of the Hygiene code to be part of routine DIPC reporting | Assured | Across the wards, we observed good practice, alcohol gels were visible and staff were using appropriate PPE. We met with both the director of infection prevention and control (medical director) and infection control lead. We heard that external advice has been sought, and no systemic issues or major recommendations were identified. The infection prevention and control team carries out regular and responsive audits, and feels sufficiently well-resourced to do so. We looked at the MRSA and *C. difficile* cases reported on ward 31. We heard that multi-disciplinary root cause analysis has been undertaken, with the outcomes being reported to the microbiologists and fortnightly operational infection prevention and control meetings. |

## Conclusion and next steps

The assurance review panel would like to thank the trust for their cooperation throughout the assurance review process. The panel felt that there was a tangible difference at the trust since the Keogh quality of care and treatment review. We observed progress against all actions during the visit and were assured that 7 of the 23 actions have now been fully addressed. The risk summit held as part of the Keogh review requested that the panel carrying out the follow-up review advise on the need for a further risk summit. The panel does not feel that a further risk summit is required.

The panel's findings will now be presented to Monitor, which as the regulator of NHS Foundation Trusts, has responsibility for monitoring progress against the agreed action plan.

**Appendix 1: Terms of Reference of the assurance visit to Sherwood Forest Hospitals NHS Foundation Trust**

Sherwood Forest Hospitals NHS Foundation Trust was one of 14 NHS hospitals inspected as part of Sir Bruce Keogh review of the quality of care and treatment in June 2013. A multiagency risk summit was held on 9 July 2013 where it was agreed that a one day site visit would be held in November 2013 to review progress made with the agreed actions. The Trust was put under 'special measures' on 16 July 2013.

Monitor has requested the support from NHS England to review the Trust's progress to date with the agreed action plan.

- NHS England will undertake a one day desk top review of the evidence provided by the Trust against the agreed action plan
- Following the desktop review a one day announced site visit will be held to triangulate the evidence received against progress made. This will comprise of meeting with the Trust Board, patients/carers and staff and undertaking ward and department visits
- The one day visit will solely be to review the progress made with the action plan and not to identify any new areas. Any new areas identified will be escalated by the panel Chair to the CQC, Monitor, CCG and Area Team for action.
- The team will be chaired by Dr David Levy and will have some members of the Keogh panel including the patient representative and representation from the Newark and Sherwood CCG and Derbyshire and Nottinghamshire Area Team
- Some preliminary feedback will be provided to the Trust at the end of the review
- The visit and feedback will be shared with Monitor and CQC
- NHS England will not be in a position to remove the 'special measure'

The announced visit is Wednesday 4 December 2013.

**Appendix 2: Panel membership**

| Panel role | Name and job title |
|---|---|
| Chair | Dr David Levy, Regional Medical Director, NHS England (Midlands and East) |
| Senior Support | Finola Munir, Regional Quality Assurance Manager, NHS England (Midlands and East) |
| CQC representative | Julie Walton, Head of Hospital Inspection, Care Quality Commission |
| Area team representative | Alfonzo Tramontano, Deputy Director of Nursing, NHS England (Derbyshire and Nottinghamshire) |
| Area team representative | Ian Matthews, Deputy Medical Director, NHS England (Derbyshire and Nottinghamshire) |
| Lay representative | Jenny Cairns |
| Senior doctor | Anna Lipp, Consultant Anaesthetist, Norfolk and Norwich University Hospitals NHS Foundation Trust |
| Board nurse | Liz Rix, Chief Nurse, University Hospitals of North Staffordshire NHS Trust |
| Senior nurse | Liz Hogbin, Head of Compliance Governance, Norfolk and Norwich University Hospitals NHS Foundation Trust |
| Clinical fellow | Leann Johnson, Clinical fellow, NHS England |
| CCG representative | Elaine Moss, Director of Quality and Governance, Newark and Sherwood CCG |
| PMO support | Jessica Seed, Development, Support and Intervention Manager, NHS England (Midlands and East) |
| PMO support | Chloe Christine-Wallis, Operations and Delivery Coordinator, NHS England (Midlands and East) |

**Appendix 3: Visit agenda**

| Time | Agenda item | | |
|---|---|---|---|
| 09.00-10.00 | Trust presentation | | |
| 10.00-10.45 or 10.45-11.30 | Interviews with: | • Chief executive<br>• Medical director<br>• Director of nursing<br>• Chair of the patient safety and quality committee | • Critical care outreach team<br>• Directors of strategy<br>• Complaints team |
| 10.45-12.45 | Ward visits: | • Emergency department<br>• Emergency assessment unit<br>• Ward 11<br>• Ward 22<br>• Ward 31<br>• Ward 33 | • Ward 34<br>• Ward 42<br>• Ward 51<br>• Ward 52<br>• Day surgery unit<br>• Theatres |
| 13.30-14.15 | Focus groups with: | • Junior doctors<br>• Staff nurses<br>• Consultants | • Ward sisters<br>• All staff |
| 14.15-15.00 | Interviews with: | • Chair<br>• Infection prevention and control lead | • Medical director and director of operations<br>• Patient advice and liaison service (PALS) |
| 14.15-15.00 | Ward visits: | • Intensive care unit<br>• Ward 36 | |
| 16.30-17.00 | Preliminary feedback to chief executive and chair | | |

**Agenda Item:**

# Board of Directors Meeting Report

**Subject:** **QUALITY GOVERNANCE FRAMEWORK**

**Date:** **30th JANUARY 2014**

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

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

## EXECUTIVE SUMMARY

The Board has previously been reminded that under the requirements of Monitors Section 105 notice and its discretionary requirements, the Trust was required to obtain external validation on the delivery of its improvements in respect of board and quality governance.

The Trust appointed PWC to undertake external validation to confirm whether:

- The Trust had delivered, in full, the Governance Action Plan
- The Trust has reached the minimum standard of quality governance required of a Foundation Trust (i.e. a score of less than 4 against Monitor's Quality Governance Framework (QGF))

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. Subsequently PWC provided external validation of the Trusts Board and Quality Governance and reported a score of 4 in January 2014. The final report from PWC providing this assurance has been received by Monitor and was the subject of a teleconference with Monitor, the Director of Corporate Services and the Head of Programme Management on 16th January.

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.

The consolidated action plan brings together the actions from the PWC report, Keogh Assurance review, CQC report and actions identified through Trust Board and relevant sub committees.

All the actions on the consolidated action plan have been collated under the appropriate QGF question providing a holistic view of the Trusts Quality Improvement and Governance agenda.

This report details progress against each of the 10 QGF questions, identifying the initial score from the PWC appraisal in January 2013, the Trust Board self-assessment in October 2013 and the PWC external validation report in January 2014.

The report highlights the areas for improvement which will be explored further through a targeted Confirm and Challenge event which is to take place on 13th February 2014

## RECOMMENDATION

1. *The Board of Directors is invited to note the contents of this report and approve the proposal for the QGF questions which require further assurance through the* ***Confirm and Challenge event 13th February 2014.***

2. *The Board of Directors is invited to approve a January score of 4 given PWC's report finalised in January 14 is considered to be an appropriately externally validated baseline. It is recommended Board seek improvements in the areas referenced above in order that a score of less than 4 be achieved and* ***reported to Board by 28th February 2014***

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** | |

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| **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:** **30th JANUARY 2014**

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

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

## BACKGROUND

The Board has previously been reminded that under the requirements of Monitors Section 105 notice and its discretionary requirements, the Trust was required to obtain external validation on the delivery of its improvements in respect of board and quality governance.

In order to achieve this, the Trust engaged PWC to undertake an Independent review of the Trust's delivery of improvements to Board and Quality Governance in November 2013; the final report was received in January 2014. This review followed on from an initial appraisal of the Trust's governance arrangements at both Board and Clinical Service level carried out by PWC in November 2012 and reported on in January 2013. In response to this the Trust developed a Governance Action Plan.

The Trust appointed PWC to undertake external validation to confirm whether:

- The Trust has delivered, in full, the Governance Action Plan
- The Trust has reached the minimum standard of quality governance required of a Foundation Trust (i.e. a score of less than 4 against Monitor's Quality Governance Framework (QGF))

*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. Subsequently PWC provided external validation of the Trusts Board and Quality Governance and reported a score of 4 in January 2014. The final report from PWC providing this assurance has been received by Monitor and was the subject of a teleconference with Monitor, the Director of Corporate Services and the Head of Programme Management on 16th January.

It is important to note, when Trust board members self-assess against best practice, they must also consider the work members have undertaken during walk-abouts, IAT visits etc. in addition to the reports it has received either from executive members or independent sources such as Internal Audit or the CQC visits for instance.

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.

The consolidated action plan brings together the actions from the PWC report, Keogh Assurance review, CQC report and actions identified through Trust Board and relevant sub committees.

The actions have been allocated for progress and monitoring to specific groups and sub committees. A Quality Improvement Group has been established to build on the progress made with the initial 13 Urgent actions from the Keogh Rapid Response Review in June 2013. This group will ensure implementation of the operational actions and provide assurance to the Trust Board via the Programme Board.

All the actions on the consolidated action plan have been collated under the appropriate QGF question providing a holistic view of the Trusts Quality Improvement and Governance agenda.

This report details progress against each of the 10 QGF questions, identifying the initial score from the PWC appraisal in **January 2013**, the Trust Board self-assessment in **October 2013** and the PWC external validation report in **January 2014**.

The report highlights the areas for improvement these will be explored further through a targeted Confirm and Challenge event which is to take place on 13th February 2014.

## QUALITY GOVERNANCE FRAMEWORK

### Strategy

**1A Does quality drive the trust's strategy?**

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|---|---|
| *PWC external review score – November 2012* | *1.0* |
| *Trust Board Self-Assessment Score – October 2013* | *0.4* |
| *PWC external review score – January 2014* | *0.0* |

There is sufficient evidence that quality does drive the Trust strategy.

External assurance is provided by PWC who report quality forms a central element of the Trust's strategic focus. The Board has oversight and control of quality performance relating to its strategy through the prioritisation of quality of care on Board meeting agendas. Focus on the trusts strategic quality priorities is demonstrable at Divisional level, evidencing that quality is the main driver for the organisation.

The Patient Safety and Quality strategy has been developed through wide consultation and once finalised and approved must be supported by a detailed implementation plan and reporting framework and communicated across the Trust and to patients and other stakeholders.

**1B: Is the Board sufficiently aware of potential risks to quality?**

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

Although there has been a significant improvement in the way the Trust assures itself regarding risks, with a much improved Board Assurance Framework supported by Divisional risk registers. PWC report further work is required to embed current processes. A particular focus is required in respect of closing the assurance gaps on the BAF and development of a Corporate Risk register. The continued roll out of the comprehensive Risk Management Training programme will ensure risks are recorded, reported and escalated appropriately.

Further work is being undertaken to ensure that the BAF is supported by a robust assurance programme that sees lead executives reporting their confidence in tested control systems in mitigating risks thereby safeguarding delivery of key strategic imperatives. The new governance structure will support this new focus and place the Audit and Assurance Committee as custodians of the BAF and associated assurance processes.

The Trust has a robust Quality Impact Assessment (QIA) process as part of the Programme Office governance process. This must be developed further to ensure the KPIs identified as part of the QIA are monitored by the project teams.

This question will be addressed in more detail through the confirm and challenge event.

**<u>Capabilities and Culture</u>**

**2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?**

| | |
|---|---|
| *PWC external review score – November 2012* | *1.0* |
| *Trust Board Self-Assessment Score – October 2013* | *0.2* |
| *PWC external review score – January 2014* | *0.5* |

There is recognition of the progress the Trust has made in this area, however the score reflects the transitional nature of the Board of Directors in the last 6 months, this has now been addressed through the appointment of substantive Non- Executive and Executive Directors, this accounts for the difference in the Trust Board Self-Assessment score when compared to the PWC score.

In order to improve the Trust board need to undertake a robust board development programme. This will help the board assess its skills and knowledge to identify further areas for development and ensure that provision of effective challenge and the understanding of the difference between assurance and reassurance is addressed. The Board is commencing its Board Development programme on 23rd January and it is important the right focus is given to ensuring Board members are all well equipped to understand and challenge the quality of healthcare services in the Trust.

**2B Does the Board promote a quality focused culture throughout the Trust?**

| | |
|---|---|
| *PWC external review score – November 2012* | *1.0* |
| *Trust Board Self-Assessment Score – October 2013* | *0.4* |
| *PWC external review score – January 2014* | *0.0* |

There has been substantial improvement in the way the Trust board has enhanced the focus of care at the Trust and promoted a quality focussed culture. The approval of the increase in nurse staffing to improve patient safety and quality demonstrates the Boards commitment to delivering quality initiatives.

There have been considerable improvements in the way the board have actively engaged with staff and patients through the 'In Our Shoes' and 'In Your Shoes' events.

The PWC report states there is a clear Board focus on quality this drives the Trust focus to prioritise a quality focussed culture.

**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* |

Board members are clear on their roles and responsibilities and this has significantly improved over the period as a result of substantive appointments of NEDs with a wide range of skills and knowledge to provide challenge to the Trust. These skills will be further enhanced through the implementation of the Board Development Programme.

There has also been noteworthy improvement in decision making and where appropriate this has been devolved to the Divisional management teams who are clear on their accountability for governance within their Division.

A significant amount of work has been undertaken to develop an Accountability Framework, starting with the formulation of an Accountability Matrix that will in due course, alongside supporting team structures be widely communicated across the Trust to ensure there is a detailed understanding of executive portfolios, accountabilities and team structures.

Further work is required to clarify the role of the Governance Support Unit (GSU) in terms of supporting governance activities at the Trust. The Trust should clearly define GSU roles and responsibilities in terms of provision of information and governance support and communicate these to Divisions to support the continued enhancement of quality governance at the Trust.

This PWC recommendation will be addressed in more detail through the confirm and challenge event and the Board previously requested that a more formal update on the restructuring of the complaints and PALS team be provided in order to understand mitigations to protect continuity of the quality of the service and the sustainability of recent improvements.

**3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?**

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

The Trust Board must be clear regarding the process for escalating quality issues through a robust escalation structure. Although there have been improvements in this area further work needs to be undertaken to ensure Committees, sub-committees and sub groups escalate issues on a timely basis from Divisions to Board. This will be addressed through the implementation of the revised committee structure and the approval of the Executive accountability matrix.

The Whistle blowing policy has been updated, revised and communicated to staff, to ensure staff are prepared, if necessary to blow the whistle. Board will need to ensure it receives regular updates on any matters raised through this policy and will also need to be assured of regular communications of the policy to sustain awareness and encourage openness.

The government report 'Putting Patients Back in the Picture' which reviews the complaints system in the NHS highlights the need for Trusts to learn from complaints and incidents. The corporate services directorate is preparing a 'true for us' statement, from which an action plan will be developed to ensure a sustainable process for learning lessons is embedded across the Trust.

Board may at some point in the future also wish to gain greater insight into the reporting culture within the Trust compared to peers particularly in terms of satisfying itself that staff are confident to report incidents because they are encouraged to do so, and also that they see improvement in services from doing so. This is also a critical element for the Trust with regard to a report to the Board in December in connection with the duty of candour, and the need to communicate incidents to patients or risk compensatory costs from future claims transferring from the NHSLA directly to the Trust.

This question will be addressed in more detail through the confirm and challenge event.

**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* |

The Trust has implemented the 'Quality for All' initiative to ensure active engagement with patients and staff. Patient and staff feedback has been proactivity solicited through listening events:

'In Your Shoes' – several events held with patients and carers, where each patient/carer was paired with a member of staff who listed to their stories and then fed back the key points to the wider group. These key points have been developed further to form the basis of the Patient Experience Strategy. Once approved the strategy must be widely communicated to patients, carers, staff and other stakeholders to ensure it is embedded across the Trust.

'In Our Shoes' – more than 200 staff attended several events where they teamed up with other staff to listen to their stories. The key points from these events have been further developed to provide the basis of the Trusts Organisational Development Strategy. Once approved the strategy must be implemented and communicated throughout the Trust to ensure the principals are embedded.

Engagement and interaction between the Board and Governors over the period has improved. The skills and knowledge audit of governors, recently undertaken, provides the basis for the Governor development programme to ensure the governors have the necessary skills to provide appropriate challenge to the Board.

**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* |

The quality and patient experience reports have improved over the period through the inclusion of narrative explaining the action being taken to enhance quality of care and address quality issues. The Board is also sighted on a range of quality metrics including performance against the Trust's quality priorities.

The quality and patient experience reports need to be developed further to include lessons learned from complaints and incidents and how these have been used to improve services. An analysis of concerns reported to PALS should also be included in the reports; this will provide further insight into patient experience.

The Trust has a Trust wide performance dashboard and this must now be developed at Specialty and Divisional level to align Board and Ward information. This should be further enhanced to include trend and triangulation of information further strengthening quality governance which has also been referenced in other parts of this report.

This question will be addressed in more detail through the confirm and challenge event.

The Board has previously discussed the need to improve integration of reporting against incidents, claims and complaints to facilitate the triangulation of data allowing a business intelligence approach in the identification of key themes and trends affecting the quality of data and the new Quality Committee will play a key role in monitoring progress and learning and also in triangulating quality information with that provided through external agency visits and inspections which will also be a key agenda item on the Quality Committee workplan

**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* |

This is the area where the Trust has made the most significant improvement. This has been achieved primarily through the establishment of a Data Quality Committee chaired by the Director of Operations and the re-establishment of the Clinical Audit Committee chaired by the Medical Director.

The Data Quality Committee is newly established to provide assurance to the Trust board in respect of the robustness of data quality to enable informed decision making and performance management. This committee, supported by the data quality group reviews the results of audits in respect of data quality and agrees and implements actions to improve performance.

PWC highlight there is evidence data quality issues exist and an internal audit of data quality relating to quality priorities, which reported in June 2013, was only able to give limited assurance due to inaccurate data and weak validation controls.

This committee and group must be developed further to provide assurance to the Board over the accuracy, validity and completeness of data quality in the Board quality, patient experience reports and ward dashboard. Trust Management Board will need to agree how this committee reports through the governance structure to ensure appropriate alignment of priorities and clear line of sight of issues. The Audit and Assurance Committee will also be agreeing an Audit Plan for the Internal Auditors which will include a clear and deliberate focus on Data Quality issues starting with an audit connected to the Monitor quarterly declaration. Board members are reminded of two of the reports from the Director of Corporate Services to the December meeting regarding the importance of Board assurance of the quality of the data on which the Trust relies in order to make decisions.

There is a weakness in Clinical audit, in that the Clinical Audit Committee did not meet for a number of months, this has impacted on the number of Audits being completed. The Interim Medical Director has re-established the Clinical Audit committee and determined the exact status of progress against the plan for 2013/14. The clinical audit plan for 2013/14 was not aligned to the quality priorities and this needs to be addressed going forward. The results of audits and agreed actions must be scrutinised by the Clinical Audit Committee and then disseminated to the Divisions for implementation. The Audit and Assurance new Terms of

Reference as approved at the December Board meeting include clarity about the Committees role in monitoring clinical audit and its role in quality and service improvement.

This question will be addressed in more detail through the confirm and challenge event.

**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* |

The Trust has improved in this area at a Trust level, however further work needs to be undertaken within Divisions and Specialties to enhance governance activities and ensure appropriate escalation of risks and issues are prioritised.

PWC note Divisional management teams are engaged in enhancing governance in their divisions and within specialties and are seeking support from the Governance Support Unit in order to achieve this.

Progress in establishing the Governance Support Unit, clarifying and formalising roles and responsibilities has been delayed. The impact of this is the establishment of consistent Divisional and Specialities governance reporting templates, meeting agendas and performance information has taken longer than expected. A substantive Head of Governance will start in February 2014

This question will be addressed in more detail through the confirm and challenge event.

**RECOMMENDATION**

4. *The Board of Directors is invited to note the contents of this report and approve the proposal for the QGF questions which require further assurance through the* ***Confirm and Challenge event 13th February 2014.***

5. *The Board of Directors is invited to approve a January score of 4 given PWC's report finalised in January 14 is considered to be an appropriately externally validated baseline. It is recommended Board seek improvements in the areas referenced above in order that a score of less than 4 be achieved and* ***reported to Board by 28th February 2014***

6. *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*

# *Sherwood Forest Hospitals NHS Foundation Trust*

## Independent review of the Trust's delivery of improvements to Board and Quality governance – Final report

13 January 2014



pwc

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# 1. Introduction and background

## 1.1. Background

In November 2012, the Trust appointed PwC to undertake a review of its governance arrangements. The purpose of the review was to appraise the Trust's governance arrangements, at both Board and Clinical Service level, in order to identify any areas for improvement.

Our findings and recommendations from this review were reported to both the Trust Board and Monitor in January 2013. In response to our findings, the Trust developed an improvement plan – the Governance Action Plan. In July 2013, this improvement plan was developed further in response to the findings of the Keogh review.

Under the requirements of Monitor's Section 105 notice, and its discretionary requirements, the Trust is required to obtain external validation on the delivery of its improvements in respect of board and quality governance. In particular, Monitor requires external validation to confirm whether:

- The Trust has delivered, in full, the Governance Action Plan provided to Monitor on in January 2013; and
- The Trust has reached the minimum standard of quality governance required of a Foundation Trust (i.e. a score of less than 4 against Monitor's Quality Governance Framework).

We have been appointed by the Trust and Monitor to undertake the external validation required by Monitor in respect of improvements to the Trust's governance arrangements. The remainder of this report sets out the findings from our work.

## 1.2. Scope and process

Our work has been undertaken in accordance with our engagement letter, dated 25 November 2013.

We have been instructed to provide an evidence based assessment of the Trust's delivery against the Governance Action Plan and to provide an independent appraisal of the Trust's current governance systems against Monitor's Quality Governance Framework. We have outlined below the detailed scope we agreed with the Trust and with Monitor:

*Delivery of the Governance Action plan*

We have been asked to provide an assessment on whether the Trust has implemented the actions detailed within the Governance Action Plan.

Our report sets out an overall conclusion on delivery of the Governance Action Plan and concludes as to whether Board governance is at least the minimum standard required of a Foundation Trust. Our recommendations are categorised by significance (i.e. in relation to the Trust's licence).

*Review and appraisal against Monitor's Quality Governance Framework*

We have provided an independent view on the Trust's quality governance systems and processes against Monitor's Quality Governance Framework. Our assessment includes a score against Monitor's Quality Governance Framework.

We have drawn upon our review and validation of the Trust's delivery of the governance improvement action plan in forming our view on the Trust's current

position against the Monitor Quality Governance Framework. This was supplemented with further work in order to gain sufficient coverage across all aspects of the framework and to arrive at an independent score.

In respect of both areas of the scope, we undertook the following work:

a) Desktop review of documentation in support of the Trust's own self assessed position, for example, quality performance reports, minutes and papers from key governance committees, divisional risk registers / improvement plans, Cost Improvement Plans (CIPs), Quality Impact Assessments (QIAs).

b) Interviews with key Executive and Non-Executive Board members and the Lead Governor;

c) Interviews with other key members of Trust staff including Divisional Management to validate the wider understanding and operation of quality governance systems;

d) Observation of the Clinical Governance and Quality Committee (CGQC), Risk Assurance Committee (RAC) and other Committees where necessary;

e) Observation of key quality governance meetings at Divisional and Service level to form a view on the operating effectiveness of governance at the Trust below Board level; and

f) Testing of core quality governance related systems and reporting including incidents, complaints, quality risk management (including CIP quality risk management) and comment on design and operating effectiveness of these arrangements.

## 1.3. Limitations of scope

This document has been prepared only for Sherwood Hospitals NHS Foundation Trust and Monitor and solely for the purpose and on the terms agreed with the Trust and Monitor.

If you receive a request under freedom of information legislation to disclose any information we provided to you, you will consult with us promptly before any disclosure. We will respond promptly to support the Trust and Monitor in meeting its obligations with regard to timescales for disclosure.

We have not carried out anything in the nature of an audit nor, except where otherwise stated, have we subjected the information contained in this report to checking or verification procedures. Accordingly, we assume no responsibility and make no representations with respect to the accuracy or completeness of the information in this report, except where otherwise stated.

Any documentation or information brought to our attention subsequent to the date of this report, which would affect our findings detailed herein, may require our findings to be adjusted and qualified accordingly.

We can provide no assurance as to whether the Trust will keep in place effective governance arrangements.

# 2. Executive summary

This summary sets out our main findings and should be read in conjunction with the rest of our report. We have made a number of recommendations which are set out within Section 5 and summarised in this Executive Summary.

## Our view on the Trust's delivery of improvements to governance

Our work has established that the Trust has implemented the majority of the planned actions aimed at strengthening Board and quality governance. In our view, a number of actions are still to be implemented fully, although the delivery of these improvements is currently in progress. In particular, the following actions require further work to ensure all planned improvements are delivered in full:

- Implementation of a Board Development programme;
- Finalisation of the corporate risk register and implementation of further risk training;
- Completion of phase 2 of the Patient Safety and Quality Strategy including communication and roll out across the Trust;
- Development of Service and Divisional quality and performance scorecards;
- Establishment of a mechanism to provide assurance over data quality of Board quality performance reports;
- Implementation of an ongoing monitoring process for Key Performance Indicators for QIAs; and
- Alignment of the clinical audit plan to the Trust's three quality priorities.

Based on our discussions with Trust management, we have categorised these actions which are still in the process of being implemented and fully embedded as follows:

1) *Actions not yet taken due to a Trust decision to defer completion*

   For example, implementation of a Board Development programme:

   The Board decided to defer a Board development programme until all substantive Board appointments were in place (from 1st December 2013). The development programme was approved in August 2013 and the Trust agreed to go out to tender. Responses to the tender are currently being assessed and the development programme is due to commence in January 2014. Executives do set objectives and objectives are currently being developed, alongside an appraisal process for Non-Executive Directors (NEDs).

2) *Actions still in the process of being completed although compensating actions and improvements have been delivered*

   For example, development of Service and Divisional quality and performance scorecards:

   Although the Trust has yet to develop integrated dashboards at Division and Service level, early warning score reports at Divisional level are provided to Divisions and the Governance Support Unit (GSU) are providing information packs to support Service and Divisional governance.

3) *Actions not complete and still in progress, but where there are clear plans in place to deliver improved process/system*

   For example, implementation of further risk training;

   The Trust has delivered risk training to a significant number of staff and provided some training to the Board. Training for the majority of Divisional and Service management (the original action) has been scheduled for January and February 2014.

The Trust has undertaken a significant amount of work across all of the actions in the Governance Action Plan. In debating their declaration to Monitor, in respect of the delivery of improvements to governance, the Trust Board considered whether sufficient work had been completed in order to be able to declare to Monitor that the action plan had been completed. The Board's view was that where action to deliver improvements to governance had commenced or where mitigating controls were in place, it could be considered that the action had been taken, even if at the time of the declaration the action had not been fully completed.

We have detailed our assessment of progress against these actions in section 3 of this report.

## Our view on the Trust's current position against the Quality Governance Framework

As a result of implementation of the majority of actions in the Governance Action Plan, the Trust has delivered significant improvement to its quality governance arrangements over the past ten months. There has been a clear focus from the Board on enhancing quality governance arrangements. Governance now has a higher profile across the Trust and there is greater ownership of governance and quality assurance within Divisions teams. We completed the majority of our fieldwork by the end of November 2013. We shared our preliminary views on the Trust's quality governance arrangements, including our view of the position against the Monitor Quality Governance Framework in early December 2013.

Since the completion of our fieldwork, the Trust has continued to strengthen quality governance arrangements in a number of areas. Further evidence was provided to us on the 19 December which demonstrated that the Trust had continued to deliver on its planned improvements. In particular, these included:

- Re-establishment of the Clinical Audit Committee, renewed understanding and oversight of the progress against the clinical audit plan for 2013/14 and development of revised terms of reference for the Audit Committee and Quality Committee incorporating responsibilities for clinical audit.
- Communication of the Patient Safety and Quality Strategy to Medical Management; and
- Further evidence of risk training provided in December 2013 and planned training for early 2014.

However, further work is needed to strengthen quality governance arrangements systems and processes in order to meet the minimum standard required of a Foundation Trust.

We have now assessed the Trust as scoring 4.0 against Monitor's Quality Governance Framework. Our assessment for each area of the Quality Governance Framework is included on page 8.

We have made a number of recommendations in section 5 of this report to further strengthen the Trust's quality governance arrangements in addition to recommendations relating to completion of actions still in progress from the Governance Action Plan.

## Our view on Board governance and effectiveness

The number of changes that have taken place in Board membership over the past six months means that the Board is still in a period of transition. The impact of this is that the Board has not yet had the opportunity to assess its effectiveness and identify areas to develop. The Board is planning to commence a Development programme in early 2014 which will further develop the effectiveness of the Board.

*Leadership*

The skills and capability of the Board have been enhanced by the NED appointments and based on our interviews, the new NEDs have a clear understanding of their role and responsibilities.

The Board is already leading a number of innovative quality initiatives and performance in relation to two of the key Trust quality priorities, pressure ulcers and mortality, indicates that the Board can demonstrate the ability to improve quality of care.

The Board is actively promoting a quality focused culture in the Trust. NEDs are engaging with both staff and patients regularly, demonstrating a commitment to understanding both patient and staff experience and the quality governance arrangements at the Trust. NEDs we interviewed demonstrated the appetite and commitment to continue to support the improvement of quality of care at the Trust.

*Board assurance and effectiveness*

At Board and Board sub-committees we observed robust questioning and challenge from NEDs. However at times we observed that there was a tendency to rely on explanations and verbal confirmations regarding progress made against agreed actions and quality of care performance rather than requesting evidence to support conclusions. The Board development programme should address how Board members seek assurance rather than reassurance.

In our view, with a comprehensive development programme the Board has the capacity and capability to continue to improve quality governance at the Trust and reach the standard of quality governance arrangements in line with those expected of a Foundation Trust.

| Area | PwC January 2013 Quality Governance Review assessment | Trust self-assessment October 2013 (average score arrived at by the Board for each area of the framework) | PwC December 2013 Quality Governance Review assessment |
|---|---|---|---|
| 1A - Does quality drive the Trust's strategy? | 1.0 | 0.4 | 0.0 |
| 1B - Is the Board sufficiently aware of potential risks to quality? | 1.0 | 0.5 | 0.5 |
| 2A - Does the Board have the necessary leadership, skills and knowledge to ensure the delivery of the quality agenda? | 1.0 | 0.2 | 0.5 |
| 2B - Does the Board promote a quality focused culture throughout the Trust? | 1.0 | 0.4 | 0.0 |
| 3A - Are there clear roles and accountabilities in relation to quality governance? | 1.0 | 0.4 | 0.5 |
| 3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? | 1.0 | 0.5 | 0.5 |
| 3C - Does the Board actively engage patients, staff and other key stakeholders on quality? | 1.0 | 0.4 | 0.5 |
| 4A - Is appropriate quality information being analysed and challenged? | 1.0 | 0.3 | 0.5 |
| 4B - Is the Board assured of the robustness of the quality information? | 4.0 | 0.5 | 0.5 |
| 4C - Is quality information being used effectively? | 1.0 | 0.3 | 0.5 |
| **Total** | **13.0** | **3.9** | **4.0** |

## Trust self-assessment against the Quality Governance Framework

In order to support its declaration to Monitor in October 2013, the Board conducted a self-assessment against Monitor's Quality Governance Framework on the 3 October 2013 following an initial trajectory discussion of progress against the Quality Governance Framework in August 2013. The Board was given a detailed briefing about Monitor's ratings and individually each Board member conducted an assessment and assigned a rating to each question in the Quality Governance Framework.

Six of the twelve Board members scored the Trust as 4 or higher indicating that, at that stage, they did not believe the Trust had reached the minimum standard of quality governance required of a Foundation Trust. Six Board members scored the Trust as 3.5 or lower. The range of scores was from 2 to 6 with an average score of 4.1. The Trust used the average score of 4.1 as the overall Board self-assessment score.

However the Trust conducted a further self-assessment as detailed in a Board paper dated 29 October which identified some further assurance had been obtained over '1B: Is the Board sufficiently aware of potential risks to quality?'.

The Trust identified that this area received a particular focus at a NED 'confirm and challenge' session with staff which provided additional assurance thereby improving the score by 0.2 and thus improving the overall assessment from 4.1 to 3.9. The Board agreed with this improvement in the overall score.

For the purposes of the table on page 8 we have provided an indicative Red/Amber/Green rating in line with the nearest rating to the Trust's self-assessed score for each question in the Quality Governance Framework.

## Summary of our view of the Trust's quality governance

*Strategy*

The Trust has established clear quality priorities and performance against these is monitored at every Board meeting, demonstrating a renewed focus on quality performance. This renewed focus on quality is also demonstrated at Divisional level where Divisional Medical Directors and Divisional Matrons were able to articulate the Trust's main quality priorities.

Phase 1 of the Patient Safety and Quality strategy has been developed and the Patient Experience Strategy is currently being developed, with engagement from Divisional and Medical Managers. The Trust will need to communicate Phase 2 of the Patient Safety and Quality strategy widely across the Trust.

Whilst there has been progress in improving how risks to quality of care are managed, risk management processes underpinning the Board and Board sub-committees are still not sufficiently robust.

Further risk management training is required at Service and Divisional management level to help support understanding of when and how to escalate risks. Trust staff, including Divisional and Service management, will be provided with this training early in 2014 with training having been provided already to a significant number of staff. Further development of risk registers is required to ensure they are effective tools for recording and discussing risks at Divisional governance meetings.

The Trust now has a robust process in place for assessing the quality impact of CIPs. Further work is needed to develop a monitoring process for Key Performance Indicators (KPIs) identified in QIAs once the CIPs have been implemented.

*Capabilities and culture*

The Board is still somewhat in transition due to the high turnover of Board members over the last ten months. However, from our interviews it is clear that both Executive and Non-Executive are committed to leading the turnaround at the Trust.

The Board leads on a number of innovative quality initiatives including the introduction of 'Care and Comfort' rounds to improve Patient Safety and Quality of care.

The Board has actively promoted a quality focused culture in the Trust. NEDs are engaging patients on a regular basis, and the Trust has held listening events with patients and staff. This has provided the Board with extra insight into patient experience and the quality governance arrangements at the Trust.

There has been a significant shift in culture at the Trust over a relatively short period of time, although it will take time to embed this culture fully.

The implementation of a range of innovative quality initiatives such as 'In your shoes' listening events, much greater engagement with staff and patients and a clear Board focus on quality indicates that the Trust now prioritises a quality focussed culture.

*Processes and structure*

Clarity over roles and responsibilities for quality governance at the Trust has significantly improved since our January 2013 review. Decision making has been devolved to Divisional Management, supported by the Executive team where necessary.

NEDs have a clear understanding of their role and responsibilities. Board development training will further enhance the effectiveness of the Board.

It is evident that Divisional management are clear on their accountability for governance within their Division and feel supported by Executives to hold Specialities to account.

In the past 6 months there have been two interim Heads of Governance and the Trust has now appointed a substantive Head of Governance commencing in February 2014. This instability has impacted on the time taken to establish an effective Governance Support Unit (GSU).

Further work is needed to clarify the role of the GSU in terms of supporting governance activities at the Trust. The Trust should clearly define GSU roles and responsibilities in terms of provision of information and governance support and communicate these to Divisions to support the continued enhancement of quality governance at the Trust.

Whilst the Trust has clear processes and structures for escalating and resolving issues from Divisions through to the Board, both Executives and Divisional management we met indicated that there is more work to be done to strengthen the reporting culture in the organisation. Whilst the Board is setting the tone from the top in terms of openness and transparency, demonstrated by for example, the Chief Executives drop in sessions for staff, embedding a reporting culture will continue to need sustained focus.

The Trust has taken significant steps to actively engage staff and patients on quality. The 'Quality for All' listening event initiative is an example of good practice and demonstrates that the Trust is seeking to shape strategy based on issues that are important to patients and staff. Development of the patient experience strategy, based on key themes from the 'In your shoes' and 'In our shoes' events will further enhance the Board's focus on experiences of patients at the Trust's hospitals.

Board members are highly visible to both staff and patients and continue to seek opportunities to speak regularly to patients about their experiences, including through patient experience stories at Board meetings.

*Measurement*

The quality and patient experience reports reviewed by the Board are significantly improved with clear narrative explaining what action the Trust is taking to enhance quality of care and address quality issues. The Board is sighted on a range of key quality metrics, including performance against the Trust's quality priorities.

The Trust has addressed Care Quality Commission (CQC) concerns relating to oversight of ward quality performance through the introduction of a new ward dashboard. Further development of this to include trend information and triangulation of key indicators will further strengthen quality governance.

The Trust is planning to develop quality performance dashboards at Specialty and Divisional level which are aligned to Board and Ward information and this will enhance the oversight and control of quality of care.

The Board is seeking to raise the profile, oversight and control of data quality at the Trust by establishing a Data Quality Committee, chaired by an Executive. Further work is needed to ensure the Board is receiving adequate assurance over the robustness of data quality used for decision making and performance monitoring.

The Clinical Audit Committee did not meet for a number of months and as a result of this there was a lack of assurance over the progress of clinical audits conducted in 2013/14. However the Board have now re-established the Clinical Audit Committee and have a clear understanding of progress against the 2013/14 plan and the work needed to complete this by the end of 2013/14.

Whilst processes for standardisation of Divisional and Service governance have been implemented, further work is needed to ensure information provided to support governance activities such as governance meeting agendas and quality performance reports are fit for purpose.

Papers for Board and Sub-Committees are not always provided to members to enable them to understand issues prior to meeting. The substantive appointment of a Director of Corporate Affairs should help to improve timeliness of Board and Committee papers.

## Recommendations and next steps

In this report, we have made a number of recommendations to further improve the quality governance arrangements at the Trust, and to embed the Governance Action Plan actions already in progress. These are detailed in full in section 5. We have summarised our recommendations below:

- Conduct risk management training in line with the Trust's plan in order to ensure service and divisional management understand what a risk is and how to report and record risks and finalise the Corporate risk register;
- Clearly define roles and responsibilities for the newly restructured GSU and further develop the information provided to Divisions and Specialities to support governance activities;
- Continue to ensure there is sufficient oversight of the clinical audit plan and actions taken to address issues identified in clinical audit;
- Ensure that the 2014/15 clinical audit plan is aligned to the Trust's three quality priorities;
- Implement phase 2 of the Patient Safety and Quality strategy and communicate this widely across the Trust, in line with the Trust's proposed timescale;
- Development of Service and Divisional quality performance scorecards and a mechanism for ongoing monitoring of QIA KPIs;
- Implement the Board development programme as currently planned;

- Ensure Board and Sub-Committee meeting papers are provided to Members on a timely basis;
- Pair Divisional and Service governance meeting Chairs with NEDs and Executives with experience of chairing committee meetings in order to provide coaching on how to chair meetings effectively;
- In line with the Trust's current plan, training should be provided to Governors to enable them to provide appropriate challenge and support in their role;
- Further development of the ward dashboard to include trend information and triangulation of key indicators; and
- Further development of Divisional risk registers is required to ensure they are effective tools for recording and discussing risks at Divisional governance meetings.

# 3. Review of improvements to governance

We have reviewed the actions taken by the Trust to strengthen its governance arrangements in line with the Governance Action Plan submitted to Monitor on 28 January 2013. The findings of our review are included below.

## Recommendations and actions completed

The Trust has implemented the majority of the actions in the Governance Action Plan. The following summarised key actions have been implemented.

- Appointing new NEDs including one with a clinical background to provide challenge and support to Executives;
- Reviewing the Executive Director's portfolios and clarifying and agreeing roles and responsibilities;
- Establishing a robust Programme Management Office (PMO) to provide challenge and support for the cost improvement programme, with rapid decision-making processes coupled with quality impact assessments integrated into project development;
- Re-structuring the Board Sub-Committees in order to establish Sub-Committees which seek assurance over risk and quality for the Board;
- Establishing clinically led Divisions supported by Executives within a clearer framework for decision making, accountability and issue escalation;
- Ensuring greater engagement with staff through team meetings, strategy events and an 'open door' policy to encourage transparency and two-way communications;
- Developing ward dashboards to provide oversight and control of quality of care;
- Enhancing Board quality reports, aligning metrics to the Trust's quality priorities and providing greater narrative describing action the Board is taking to address quality issues;
- Development of a patient experience Board report with a wide range of patient experience indicators;
- Development of phase 1 of the Quality and Patient Safety Strategy;
- Development of a clinical services plan/strategy in conjunction with stakeholders and clinical staff; and
- Introduction of Governor induction training.

## Recommendations and actions in progress

Whilst significant progress has been made, in our view, a number of actions are still in progress. We have detailed the current status against these actions in the table on the following page. We have detailed a summary of the recommendations that need further work in section 5 of this report.

| Governance Action Plan 28 January 2013 reference | Actions in progress | Current position |
|---|---|---|
| 1 | **Skills and capability of the Board**<br><br>Training at an individual and collective level should be provided to all Trust board members in the short term and an ongoing development programme that feeds into an appraisal process should be developed for implementation in 2013/14 (original deadline 30 September 2013) | Due to the Board only recently appointing substantive NEDs, a development programme has not yet commenced. The Board has put out a tender for Board development and is expecting to commence this programme in January 2014. |
| 5 | **Risk management**<br><br>The Trust has delivered the majority of actions relating to recommendation 5. However the following points are still in progress:<br><br>Risk management training should be provided to Service and Divisional management covering how to assess and moderate risks and how to document these on risk registers. (original deadline 31 March 2013)<br><br>A Trust wide corporate risk register should be developed, building on the existing high risk register. The Trust wide corporate risk register should cover risks escalated from all Divisions within the Trust, including the central Division. | Risk management training has been provided to a significant number of staff although more training is scheduled in for January and February 2014 for Divisional and Service management.<br><br>A Trust wide corporate risk register is still being developed and has yet to be presented to the Risk Assurance Committee or the Board although this is planned for December 2013. However high rated risks from across the Trust are debated at the Risk Assurance Committee which acts as a mitigating control. |

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| 9 | **Quality strategy**<br><br>In line with good practice, the Trust should develop a quality strategy with a small number of improvement objectives, engaging with Service level clinical teams, patients and Governors in its development.<br><br>The development of a quality strategy should be Board led with appropriate Executive leadership. The Board needs to be clear about the current standard of quality arrangements at the Trust, what the priorities are and why and what the pace of change will be. The strategy should be developed in consultation with external stakeholders, service users and staff (such as through town hall events). (original deadline 30 June 2013). | The Trust has developed phase 1 of the Patient Safety and Quality strategy, engaging with Divisional and Medical management to ensure the quality priorities are appropriate. This strategy has been distributed amongst the Divisions, service lines and medical managers. It was discussed at the October Trust Board meeting.<br><br>As part of phase 2 of the Patient safety and Quality strategy is being reviewed in conjunction with the patient experience strategy and is due to be completed by January 2014 and will be formally adopted and rolled out across the Trust.<br><br>Whilst the strategy has not yet been finalised, the Trust has taken clear and extensive steps to develop this and ensure there is extensive engagement with patients and staff. The strategy has also been discussed at strategy days for the Board. |
| 13 | **Performance management scorecards**<br><br>(original deadline 30 March 2013)<br><br>All scorecards should be aligned from Ward to Board. Trust level data should be supported by a pyramid of more granular data. Specifically:<br><br>• consistent indicators should be measured;<br>• targets should be identified where appropriate and lack of target explained where not;<br>• cumulative performance should be considered as well as in-month performance; and<br>• indicators should reflect direction of travel as well as performance against targets. | Whilst the Trust has developed a new ward dashboard which has been produced for the first time in May 2013 and the Board quality report has been developed and improved, there remains work to be done on development of quality performance scorecards at Service and Divisional level.<br><br>As a mitigating control Divisions receive a Division specific Early Warning Dashboard on a monthly basis.<br><br>See further information for reference 14 and15 below. |

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| 14 and 15 | **Divisional and Service level performance reporting**<br><br>(original deadline April 2013)<br><br>**Divisional level performance information**<br><br>A Divisional quality and patient safety dashboard should be developed. A more granular version of the early warning dashboard with additional Division specific metrics would be appropriate and would therefore support the early warning dashboard with a pyramid of more granular data.<br><br>A consistent pack of information should be developed for Divisional governance meetings that includes, but is not restricted to:<br><br>▪ quality & patient safety dashboard;<br>▪ risk register;<br>▪ SI data and RCAs where appropriate;<br>▪ incident log for all incidents including status, due date, owner and action plan;<br>▪ complaints data including specific complaints which are relevant across Specialties;<br>▪ lessons learnt;<br>▪ mortality;<br>▪ clinical audit;<br>▪ workforce information, i.e. mandatory training;<br>▪ Service level reports; and<br>▪ key messages from the Board.<br><br>The information should be granular enough to identify outliers, highlight themes and trends and result in actions or sharing of lessons learnt. | The GSU has recently developed a pack of information which is sent out to Specialties and Divisions to support their governance meetings. However the Trust is still developing and improving the information provided. For example, further information is needed relating to trends and themes for complaints. The GSU structure is being re-designed and the formal roles and responsibilities related to supporting Divisional and Service governance are therefore not embedded. In addition as per comments above for reference 13, the Divisional quality and performance dashboard has yet to be developed.<br><br>Currently Specialties are receiving a performance scorecard which includes a small number of quality measures and does not align to quality performance information at Ward or Board level. The Trust is aware of the need to further develop quality performance reporting and a working group has met once already and is due to meet again at the end of November to commence this project. The working group will include the Head of Information, Director of Nursing and Quality and the Medical Director. |

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| | **Service level performance information**<br>A consistent pack of information should be developed for Service governance meetings that includes, but is not restricted to;<br>▪ quality & patient safety dashboard;<br>▪ risk register;<br>▪ SI data and RCAs where appropriate;<br>▪ incident log for all incidents including status, due date, owner and action plan;<br>▪ complaints data and themes;<br>▪ lessons learnt;<br>▪ mortality;<br>▪ clinical audit;<br>▪ workforce information, i.e. mandatory training; and<br>▪ key messages from the Board. | |

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| 16 | **Data quality**<br><br>The Board should consider how it is being assured that information reported on quality and safety presents an accurate view of performance. (original deadline February 2013) | The Trust does conduct data quality audits related to the quality priorities and other specific quality measures such as cancer waiting times. However, whilst the Board has developed the new quarterly quality report and ward dashboard, there are no robust mechanisms in place that provide the Board with assurance over the accuracy, completeness and validity of data included in these reports.<br><br>As a compensating control Directors review board reports for reasonableness prior to being presented to Board.<br><br>The Ward Assurance dashboard and the Quality Board reports have been redeveloped recently and going forward it is important that the Board receives assurance over these specific reports as they are used for quality performance management and decision making. |
| 18 | **Monitoring the impact on quality of CIPs**<br><br>The Trust should implement a monitoring process for CIPs that includes early warning KPIs for potential impacts on quality of care. Divisional management should be responsible for reviewing the quality impact of CIPs in their Divisions. | Whilst the Trust has developed a robust process for assessing the impact on quality for CIPs, further work is needed to ensure that the KPIs identified within QIAs are monitored on an ongoing basis. Currently there is no clear mechanism to support Divisions in reviewing these KPIs. The responsibility for reviewing KPIs is with the project teams. The Trust should consider incorporating these into the Divisional quality dashboards (see reference 14 and 15).<br><br>The Trust has some mitigating controls in that early |

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| | | warning dashboards and the ward assurance report cover some of the KPIs related to QIAs. The Trust is intending to develop KPIs for QIAs within the Divisional scorecards. |
| 22 | **Clinical audit assurance**<br><br>The clinical audit plan for 2013/14 should be aligned to the quality priorities for the Trust. The plan should be developed in line with best practice, as detailed within the Healthcare Quality Improvement guidance for clinical audit (2010) developed by the Good Governance Institute. The plan should be signed off prior to 1 April 2013 by the Executive lead to confirm that the Board has plans in place to receive assurance from clinical audit in respect of specific quality priorities.<br><br>Action plans following clinical audits should receive challenge and scrutiny. This can be achieved by either:<br><br>• revising the terms of reference for the Clinical Audit Committee to ensure there is challenge over action plans to address clinical audit recommendations in high risk and strategic quality priority areas: or<br>• mandating review and challenge of clinical audit actions at Divisional governance meetings to ensure actions are carried out in line with agreed actions/timeframes. | The 2013/14 clinical audit plan is not aligned directly to the Trust's three quality priorities. There is only one audit linked to Trust priorities, 'Acute Kidney Injury' within the mortality work-stream. However the plan does align to many of the Trust's Commissioning for Quality and innovation (CQUIN) targets and other areas of focus such as falls assessments and hand hygiene.<br><br>The Clinical Audit Committee did not meet for a number of months and there was no oversight and control of the clinical audit plan for a significant period in 2013/14.<br><br>The new Medical Director has addressed this by re-establishing the Clinical Audit Committee and establishing what work needs to be conducted to complete the plan by the end of 2013/14. Terms of reference for Audit Committee and Quality Committee have been revised to reflect their responsibilities for oversight of clinical audit.<br>The Trust should continue to ensure there is sufficient oversight of the clinical audit plan and actions taken to address issues identified in clinical audit. |

# 4. Our view of the Trust's current quality governance position

We have conducted an assessment of the Trust's current governance arrangements against the Monitor Quality Governance Framework, using the assessment ratings applied by Monitor when undertaking a formal assessment of quality governance. This section sets out the findings from our assessment.

As part of the annual Compliance Framework the Trust is required to declare to Monitor, with regard to the Quality Governance Framework, that adequate arrangements exist for ensuring safe, effective and high quality care at all times. It is Monitor's expectation that all trusts should work towards achieving 'Green' for each of the ten areas within the framework. The rating for each area was determined by comparing the Trust's current arrangements we observed against examples of expected and good practice as specified within the Monitor Quality Governance Framework. The definition of these ratings is set out opposite.

If the Trust were being formally assessed as an applicant Trust, in order to be authorised it would need to demonstrate a score of less than four with an overriding rule that none of the four categories of the Quality Governance Framework (Strategy, Capabilities and Culture, Processes and Structure and Measurement) to be entirely Amber/Red rated.

| Rating | Score | Definition | Evidence |
|---|---|---|---|
| Green  | 0.0 | Meets or exceeds expectations. | Many elements of good practice and there are no major omissions. |
| Amber / Green  | 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. |
| Amber / Red  | 1.0 | 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. |
| Red  | 4.0 | Does not meet expectations. | Major omission in quality governance identified. Significant action required with limited plans in place to address omission. |

# 4.1. Strategy

## 1a – Does quality drive the Trust's strategy?

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|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Quality priorities*

The Trust has five strategic priorities for 2013/14; quality is a key element of two of these (priority 1 and priority 2):

1. Achieve the best patient experience
2. Improve patient safety and provide high quality care
3. Attract, retain and motivate an appropriately trained workforce
4. Financial sustainability
5. Excellent relationships with external organisations/regulators

The Trust also developed 3 quality priorities for 2013/14 through consultation with Governors, Commissioners and clinical management:

- Priority 1 – Improving the effectiveness of care we deliver by achieving a reduction in mortality (HSMR, SHMI and crude mortality);
- Priority 2 – Delivering Harm Free Care by reducing hospital acquired pressure ulcers; and
- Priority 3 - To reduce length of stay and readmissions by improving patient flows (i.e. reducing the number of bed movements during the patients inpatient stay).

The Trust has established a new quarterly quality Board report commencing in quarter 1 2013. The report tracks performance against the three quality goals for 2013 alongside a range of other quality indicators**.**

In addition in between these quarterly reports, the Board receives a monthly quality report which also includes an assessment of performance for each of the three quality priorities.

The Trust has demonstrated significant improvement for priority 1, improving mortality and for priority 2, avoiding hospital acquired pressure ulcers. For priority 3 the Trust has reduced length of stay, although it is behind the Trust target. Readmissions information is not deemed to be reliable as the Trust is currently conducting a coding exercise to improve the quality of the data.

Quality goals are well known across the Trust. Divisional management we met were able to describe the top three priorities, although it is evident that the priorities with the highest focus are the reduction in mortality and pressure ulcers.

The Board prioritises quality of care on Board meeting agendas, demonstrating the renewed focus of the Board on seeking assurance over the quality of care at the Trust.

*Patient Safety and Quality Strategy*

The Trust has developed phase 1 of the Patient Safety and Quality Strategy, engaging with Divisional and Medical management to ensure the quality priorities are appropriate. Within the strategy the key areas of focus for the Trust are:

- Reduce mortality
- Reduce harm
- Provide reliable care
- Improve experience of patient care

Phase 2 of the Patient Safety and Quality Strategy is being developed in conjunction with the patient experience strategy and is due to be completed by January 2014 and will be formally adopted and rolled out across the Trust.

The Trust has developed a clinical service plan (October 2013). The plan sets out the Trust's vision for providing high quality cost effective care for patients and how to work with partner organisations in health, social care and local services.

The Mid-Notts Integrated Care Transformation Programme has been developed across health and social care within Mansfield, Sherwood Forest and Ashfield in order to create a blueprint of how health and social care should look over the next 5 years. The Trust has been working closely with a range of partner organisations (including the Clinical Commissioning Group) in order to develop this programme

*Our view*

In our view, quality now forms a central element of the Trust's strategic focus. Measuring performance for the Trust's three quality priorities at each Board meeting ensures that the Board has oversight and control of quality performance related to its strategy.

The Board prioritises quality of care on Board meeting agendas, demonstrating the renewed focus of the Board on seeking assurance over the quality of care at the Trust.

This renewed focus on quality is also demonstrated at Divisional level where Divisional Medical Directors and Divisional Matrons were able to articulate the Trust's main quality priorities.

The Trust has yet to finalise the new Patient Safety and Quality strategy as it is seeking to incorporate feedback from recent patient and staff engagement events. When finalised, the Trust should seek to communicate the strategy widely to staff, patients and other stakeholders.

## 1b – Is the Board sufficiently aware of potential risks to quality?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Board Assurance Framework (BAF) and Corporate Risk Register*

The BAF has been through a number of iterations this year. As a result of the continued focus on the development of the format and content of the BAF document, it has not been used to drive discussion or facilitate assurance to the Board.

The BAF was presented to the Board in October 2013 with a recommendation that a further review is undertaken to ensure it is fit for purpose. An updated and improved version was presented to the November Board meeting and subsequently to November RAC. The latest BAF does contain relevant quality risks in relation to mortality and prevention of patient harm including pressure ulcers.

The corporate risk register is still being compiled and has not been presented to RAC or Board as yet although the RAC does debate high rated risks on a regular basis from across the Trust.

*Recording, reporting and escalation of risks*

Reporting to the RAC by Divisions is of variable quality and detail. In addition papers are sometimes provided late, giving committee members insufficient time to read and digest the information they contain.

For the 13 November RAC meeting we observed, papers were provided to Committee members the day before the meeting. The risk reports provided by the Planned Care and Surgery (PCS) and Diagnostics and Rehabilitation (D and R) Divisions did not sufficiently describe the nature of the risk, or the controls and mitigations being implemented. At the RAC meeting we observed, these report issues were challenged by the chair and Divisions were asked to provide reports of similar detail to the Emergency care and Medicine (ECM) risk report in future. The committee operated effectively and through challenge, drew out the missing report detail through questioning.

Our interviews with Board members and other staff highlighted concerns that risks are not always being escalated in a timely manner and that therefore the Board may not have sight of emerging quality issues. One example related to a risk of failure to decontaminate mattresses after use which was only recently escalated. Investigation by the Trust has shown this to have been an issue for some time. As the Board were unaware of the issue, no response was formulated to purchase additional mattress and decontaminate the backlog until October 2013.

Risk management training has recently been provided to a significant number of staff. Further training is scheduled in for early 2014 and this will include Divisional and Service management. This training will further support development of a risk management and reporting culture at the Trust.

The three Divisional risk registers vary in quality and format. The October 2013 ECM risk register was well documented with risks comprehensively explained and the register shows clearly the date risks opened, actions taken to date and next steps. The oldest risk dates from December 2012.

The October 2013 D and R Division risk register had 41 risks in total, including a number of duplicate risks. The nature of risks and actions to mitigate are not fully explained. The register would benefit from review to see if some risks can be combined or removed. The risk register shows evidence on ongoing updates to actions but the format makes it difficult to track agreed actions and timeliness.

The October 2013 PCS risk register contains evidence of recent actions against risks; however the oldest risk relating to failure to meet target referral times dates from Nov 2009, indicating older risks are still staying on risk registers without resolution.

*Quality impact assessments*

A robust PMO has been established, with assessments of quality impact as a core part of the development of projects and service changes. New ideas for CIPS are presented to Executives with an overview of any potential impact on quality. An initial go/no go decision is taken, which includes consideration of the quality impact by the Medical Director and Director of Nursing and Quality.

All QIAs, which are developed once the initial decision about a project has been made, are reviewed and approved by the Divisional Medical Director, the Executive Director of Nursing and Quality and the Executive Medical Director. The Medical Director and Director of Nursing and Quality consider the cumulative effect of schemes and any unintended consequences.

There is clear evidence of QIAs being rejected where the Director of Nursing and Quality has raised concerns. For example, a CIP related to implementation of a revised Patient Pathway Co-ordinator Model to improve the quality of patient administration services provided by the Trust was rejected as the impact of quality was deemed to have been much greater than the initial QIA suggested. This CIP is currently under review.

Whilst quality KPIs are identified within the QIAs, the Trust has not yet established a routine method of monitoring them for ongoing quality impact. The Trust should implement a monitoring process for CIPs that includes early warning KPIs for potential impacts on quality of care. Divisional management should be responsible for reviewing the quality impact of CIPs in their Divisions.

*Our view*

The latest version of the BAF is appropriate to facilitate Board assurance going forward provided the current gaps in assurance are filled.

The Risk Management Committee operates effectively with good challenge and exploration of issues, however information reported to the Committee should be more timely and complete.

Further development of risk registers is required to ensure they are effective tools for recording and discussing risks at Divisional governance meetings. The ECM risk register is a good practice example which can be used as a basis for how the Divisional risk registers should be completed.

The Trust now has a robust process in place for assessing the quality impact of CIPs. Further work is needed to develop a monitoring process for KPIs identified in QIAs once the CIPs have been implemented.

Risk management training has recently been provided to a significant number of staff and this will further support development of a risk management and reporting culture at the Trust.

# 4.2. Capabilities & culture

## 2a – Does the Board have the necessary leadership, skills and knowledge to ensure the delivery of the quality agenda?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Board skills and development*

There has been significant turnover in Board members in the past six months. Six new NEDs are now in post, including the Chair. The NEDs have a wide range of experience in the NHS and in the commercial sector. The Board now has a NED with a clinical background to help support understanding and to provide challenge for quality issues.

Due to the new Board only recently being formed, the Board development programme has been delayed. The Trust has recently commenced a procurement process for Board development support and the programme is expected to begin in January 2014.

At Board and Board sub-committees we observed robust questioning and challenge from NEDs. However at times we observed that there was a tendency to rely on explanations and verbal confirmations regarding progress made against agreed actions and quality of care performance rather than requesting evidence to support conclusions. The Board development programme should address how Board members seek assurance rather than reassurance.

*Board leadership and knowledge*

NEDs we interviewed demonstrated the appetite and commitment to continue to support the improvement of quality of care at the Trust.

All NEDs we interviewed were aware that mortality was a priority and most identified pressure ulcers as a priority. Other responses focussed on a range of issues including the organisational structure, complaints and risk management, as well as clinical quality. This is indicative of the vast challenges the Trust has faced over the past year.

When questioned about the Trust's quality and performance, Executives observed that the new Board quality report has made a significant difference to their understanding and ability to digest information quickly.

NEDs were able to articulate the quality reporting and escalation structures within the Trust, including how that Specialties report through to Divisions and subsequently to Clinical Management Team, Risk Assurance Committee and Clinical Governance and Quality Committee.

The Board has led a number of initiatives to improve quality performance. The Board has focused on initiatives to address the 3 quality priorities for 2013/14 and there have been significant improvements, particularly for mortality and pressure sores.

The Board has introduced a 'Care and Comfort round' for patients to improve patient safety and an 'In your shoes' and 'In our shoes' patient and staff engagement programme to ensure that the patient engagement strategy is based on real experiences.

The quarterly quality report includes clear information on actions the Trust is taking to improve quality for each of the CQUIN payment framework as well as wider quality initiatives.

*Our view*

The number of changes that have taken place in the Board over the past 6 months mean that the Board is still somewhat in transition. However, from our interviews it is clear that both Executive and Non-Executives are committed to leading the turnaround at the Trust.

The Board is leading a number of innovative quality initiatives and performance in relation to two of the key Trust quality priorities, pressure ulcers and mortality indicates that the Board can demonstrate the ability to improve quality of care.

As the Board is relatively new, there are still some gaps in skills. The Board should continue to assess its skills and knowledge to identify further areas for development and ensure that provision of effective challenge and the difference between assurance and reassurance is addressed through the Board development programme.

## 2b – Does the Board promote a quality focused culture throughout the Trust?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Quality initiatives*

The Board has led the development of a number of quality initiatives, including the 'Quality for all' programme, which involved holding listening events for patients and staff in order to identify common values.

A number of staff and patient engagement events have already taken place, further detail on these are included in '3c – Does the Board actively engage patients, staff and other key stakeholders on quality?'.

During quarter 22013/14 the Trust embarked on a 'Knowing how we are doing' pilot project for patients and staff on one ward (ward 24). The project has now been rolled out across the Trust in November 2013 following feedback and any changes/improvements needed from the pilot.

The aim of the project is to define a standardised approach to displaying important information to patients and staff via the ward boards including:

- Photos of staff and what their role is so patients and visitors can identify what the uniforms mean;
- Information about staffing levels on shift and leadership rounding;
- Safety information that shows the number of pressure ulcers, falls and medication errors;
- Friends and family test scores; and
- Information about visiting times and how to prevent the spread of infections.

'Care and Comfort' rounds have been introduced and are designed to help create a safer hospital environment and to reduce patient harm by proactively checking patients.

The rounds are hourly between 8am and 10pm and every other hour between 10pm and 8am. Nurses have a '4ps' checklist for these rounds which includes:

- Pain assessment;
- Personal care: Assistance to use toilet, assistance with nutrition;
- Position: Assistance to alter position or encourage movement; and
- Possessions: Assistance with hydration, ensure all essential items are within reach e.g. call buzzer.

The rounds also include an environment scan, checking for falls hazards and keeping the area around beds clutter free. The Trust anticipates that these rounds will improve patient safety in a number of ways including reduction in pressure ulcer prevalence, reduction in falls, increase in hydration and improved patient experience.

*Board engagement with patients and staff*

The Chairman and other NEDs frequently visit wards. The Chairman has worked shifts as a healthcare assistant in order to gain greater visibility over quality of care at the Trust and to engage with both staff and patients. NEDs recently held a check and challenge session with clinical staff in order to understand further how governance is operating at the Trust and to demonstrate the importance the Board places on quality of care.

Enhanced clinical leadership within the Trust has been achieved, through creating a triumvirate Divisional Management structure composed of a Medical Director, Divisional Matron and a General Manager.

The Board has devolved decision making to the three Divisions, whilst ensuring there is sufficient support from Executives within the new structure. Establishment of the Clinical Management Team (CMT) and Hospital Management Board (HMB) enables the Board to have appropriate oversight of Divisions for quality and operational matters. These forums also support cross-Divisional learning.

The Chief Executive holds monthly briefing sessions with staff, through which messages relating to quality initiatives, quality performance and other matters are raised.

From our interviews with Board Members and clinical staff it is clear that the changes have had a positive impact on the profile and ownership of quality governance.

*Our view*

In our view, the Board has taken significant steps in enhancing the focus on quality of care at the Trust and has actively promoted a quality focused culture in the Trust.

NEDs are engaging with both staff and patients on a regular basis, providing them with extra insight into patient experience and the quality governance arrangements at the Trust.

There has been a significant shift in culture at the Trust over a relatively short period of time, although this will necessarily require time to be fully embedded.

The implementation of a range of innovative quality initiatives such as 'In your shoes', much greater engagement with staff and patients and a clear Board focus on quality indicates that the Trust now prioritises a quality focussed culture.

# 4.3. Processes & structure

## 3a – Are there clear roles and accountabilities in relation to quality governance?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Board roles and accountabilities*

Through discussion with Executives and NEDs it is apparent that the whole Board understands its accountability for quality.

The Director of Nursing and Quality is the designated lead for quality and the Medical Director is the designated lead for patient safety. The Trust has appointed a NED with a clinical background who is the NED lead for clinical and quality matters. However each NED and Executive we interviewed was clear that the Board is responsible for ensuring that quality of care is of a high standard at the Trust.

The Chairman is developing a 'Ward and Department Pairing Initiative' which will pair NEDs, Governors and Executives to specific wards and departments to ensure that the Board and the Governors are visible and engaged with staff and patients for all of the Trust's services.

Accountability and ownership has been enhanced through clarification and agreement of Executive portfolios. Portfolios cover all operations at the Trust including governance, data quality and clinical audit, areas which previously lacked clarity over ownership. The Trust has developed an accountability matrix which specifies which Executive is responsible for each area of responsibility in the Trust. Executives we met expressed clarity over roles and responsibilities in terms of their portfolios and Divisional management were clear about who they reported to.

The Board has yet to undergo a Board Development programme. This will be essential to further support clear roles, responsibilities and accountability.

*Divisional and Service roles and accountabilities*

There are clear and well understood performance management arrangements for the Divisions including monthly performance meetings with the Director of Operations where Divisional management are held to account for achieving agreed objectives.

Divisional Medical Directors and Heads of Nursing are able to clearly articulate roles and responsibilities for quality governance at Divisional and Specialty level.

There is a clear understanding of the responsibility of Divisional management to hold Service Medical Directors and Matrons to account for governance activities.

To support Divisional and Service level governance, in May 2013 the Trust was seeking to establish a central Governance Support Unit, overseen by a Head of Governance, reporting to the Executive Director of Nursing and Quality.

Subsequent to this two interim Heads of Governance have been appointed and left the Trust and the Trust has now appointed a substantive Head of Governance, commencing post in February 2014.

Progress in terms of establishing the GSU, clarifying and formalising roles and responsibilities has been impacted by the lack of stability in the Head of Governance position.

We observed one Divisional governance meeting and three Service meetings.

All of the meetings had good discussion and participation from attendees and there was clear appetite to address risks and issues. Some information the GSU was expected to provide was missing, for example, one Service did not receive their risk register, another was missing the early warning scorecard and another was still waiting on some case notes for a mortality review.

Whilst the commitment to ensuring governance is improved is clear from both Divisional and Service management, there is scope to develop the effectiveness of the governance meetings. Specifically, Divisional and Service management chairing these meetings may benefit from coaching and advice on how to chair governance meetings effectively from NEDs with appropriate experience.

Divisional management we met all explained that governance is now seen as much more of a priority in the organisation and attendance at Divisional governance meetings is generally good with wide participation in discussions. This was supported by our observation of governance meetings.

*Our view*

Clarity over roles and responsibilities for quality governance at the Trust has significantly improved since our January 2013 review. Decision making has been devolved to Divisional Management, supported by the Executive team where necessary.

The skills and capability of the Board has been enhanced by the NED appointments and the new NEDs have a clear understanding of their role and responsibilities. Board development training will further enhance the effectiveness of the Board.

It is evident that Divisional management are clear on their accountability for governance within their Division and feel supported by Executives to hold Specialities to account.

Support should be provided to Divisional and Service management regarding chairing governance meetings. NEDs with experience in chairing committee meetings should be paired up with Divisional and Service management in order to provide coaching and support.

Further work is needed to clarify the role of the GSU in terms of supporting governance activities at the Trust. The Trust should clearly define GSU roles and responsibilities in terms of provision of information and governance support and communicate these to Divisions to support the continued enhancement of quality governance at the Trust.

## 3b – Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Escalation structures and processes*

The Trusts Board sub-committees and sub-groups provide a clear structure to escalate issues on a timely basis from Divisions through to the Board.

Operational issues are escalated through the HMB and clinical and quality matters are escalated through the CMT.

Divisional management we met expressed clarity about escalation channels for risks and quality issues. The CMT provides assurance to the Clinical Quality Governance Committee (CQGC) on governance matters and the HMB provides the

Executive team with increased oversight and control of operational and financial performance.

The CMT is attended by the Medical Director and Lead Nurse from each Division as well as the Executive Director of Nursing and Quality and Executive Medical Director. The CMT enables the Board to hold Divisional management to account for quality of care and enables Divisional Management to raise concerns and issues they have which are then escalated to the CGQC where necessary.

Each Service and each Division holds a monthly governance meeting with issues escalated from Service to Division and subsequently to CMT and CQGC and the Board if necessary.

*Reporting culture and learning from issues*

The Board recognises that further work is required to continue to develop a culture of openness and transparency at the Trust. The Board is continually emphasising the need to be open and ensure that reporting of issues becomes the norm. The Chief Executive holds regular drop in sessions where any member of staff can discuss any issues plus the Chairman and other NEDs conduct extensive and regular ward visits, speaking to staff and asking them about any quality related issues.

The Board recognises that further work is needed to ensure that there is sufficient Trust wide learning from quality issues. Divisional management are responsible for investigating and learning from incidents, complaints and other quality issues within their Division. Divisional management we met understood this responsibility; however they expressed a need for further support from the Central Governance Unit in analysing information and identification of trends in order to support this learning.

The CMT meetings, attended by all of the Divisions management, provide a forum to enable some Trust wide learning from quality issues and Divisional Management we met confirmed that they would highlight issues identified which might affect other Divisions. However there is no formalised mechanism for this and therefore a risk that Trust wide issues might not be identified and mitigated.

The Trust has a whistle-blowing policy which is available on the Trust intranet. The policy sets out clear steps to be taken in the event of concerns which need escalating. The Trust updated the policy following the January 2013 PwC governance review and the Keogh review to ensure that it was clear that anonymous reports would be investigated and that whistle-blowing reports would not be held on the reporter's personnel file. The policy has also been updated to make sure that it is clear how important it is to be transparent and report concerns. The tone of the policy now indicates that the Trust values concerns that are raised.

*Our view*

The Trust has clear processes and structures for escalating and resolving issues from Divisions through the Board and the Board sub-committees. The introduction of the CQGC and the CMT meeting provide a clear route for quality issues to be escalated from Divisions and for communications from the Board and Board Sub-Committees to be cascaded through the Trust's governance structure.

Divisional management are clear on their responsibility for escalating issues from Specialties where necessary and are able to articulate clearly the escalation channels available.

The Board is setting the tone from the top in terms of openness and transparency, demonstrated by for example the Chief Executives drop in sessions but embedding a reporting culture will continue to need sustained focus. Risk management training will help support the development of this reporting culture.

In addition there is further work to be done to ensure lessons are being learned from incidents, complaints and other quality issues.

## 3c – Does the Board actively engage patients, staff and other key stakeholders on quality?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

The Trust has developed the 'Quality for All' initiative in order to enhance the engagement of staff and patients in the Trust's patient experience strategy. The focus is on identifying a set of values shared by staff and patients, based on what is important to them. Listening events have been held with both patients and staff:

- 'In your shoes' – a number of events were held with patients and carers. Each carer/patient was teamed up with a member of staff who listened to their stories
- 'In our shoes' - over 200 staff attended events where they were paired up with other staff to listen to their stories. 'Graffiti Boards' were used to capture thoughts across the Trust.

The Board were presented with the results from these sessions on the 7th November.

The patient experience strategy was originally due to be completed during summer 2013. Therefore there has been a delay in developing this. Through discussion with Executives, it is clear that Trust wanted to fully engage staff and patients and develop the strategy using a bottom up approach to ensure it was effective and meaningful. The Trust has now completed the patient and staff experience consultation and, using an external consultancy firm, is analysing and developing themes from these events and patient survey and other information to support the development of the strategy.

Engagement and interaction between the Board and Governors was described by the Lead Governor has being much more open. Governors are now encouraged to interact with patients, for example the Lead Governor has worked on a night shift as a Healthcare Assistant.

Other than induction training, Governors have not received training and developmental support. The Trust has recently conducted a skills audit of Governors in order to identify their individual training needs and a programme of training has been developed to commence in January 2014.

There is enhanced communication and openness with patients through the 'Knowing how we are doing' project for patients and staff. The aim of the project is to define a standardised approach to displaying important information to patients and staff via the ward boards The project has been rolled out across the Trust in November 2013. The Chairman frequently visits the hospitals, speaking to staff and patients about their experiences. The Chief Executive holds monthly briefings with staff along with drop in sessions which are open to all staff. These provide a further opportunity for staff to engage with the Trust leadership. The Trust Board also listens to a patient story at each Board meeting.

Divisional management we met described significant engagement with NEDs, including through 'Check and Challenge' sessions where NEDs probe how governance is working within the Divisions.

The Trust has introduced a new 'home visit' process following a complaint. If appropriate and in agreement with the complainant, staff visit the complainant in their own home to discuss what happened and what the Trust can do to rectify the situation.

*Our view*

The Trust has taken significant steps to actively engage staff and patients on quality. The 'Quality for All' initiative is an example of good practice and demonstrates that the Trust is seeking to shape strategy based on issues that are important to patients and staff.

Development of the patient experience strategy, based on key themes from the 'In your shoes' and 'In our shoes' events will further enhance the Board's focus on experiences of patients at the Trust's hospitals.

Board members are highly visible to both staff and patients and continue to seek opportunities to speak regularly to patients about their experiences, including through patient experience stories at Board meetings.

The Trust should also ensure that training and developmental support for Governors is provided in line with the Trust's plan to ensure they are able to provide appropriate challenge to the Board.

## 4.4. Measurement

### 4a – Is appropriate quality information being analysed and challenged?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Board quality performance reporting*

The Trust has established a new quarterly quality Board report commencing in quarter 1 2013. The report tracks performance against the three quality goals for 2013/14 alongside a range of other quality indicators**.** In addition in between these quarterly reports, the Board receives a monthly quality report which also includes an assessment of performance for each of the three quality priorities and an update of performance against other quality measures.

The quarterly quality report includes an executive summary with key points drawn from the underlying quality metrics and measures. The report includes clear measures against the three quality priorities, CQUINs, serious incidents and a range of other key areas of quality focus for the Board.

The report details some Trust wide key quality initiatives underway such as the 'Care and Comfort rounds'. Following this each quality measure is set out with target, performance, narrative about the performance and information about key initiatives currently underway to improve quality.

The report provides a clear analysis of not just performance but what the Board is doing to actively improve quality.

The monthly quality report also reports on progress against the quality priorities. However, the other information in the quality report focusses on the following:

- Complaints performance;
- Some patient experience information (Friends and Family and PLACE where available);
- Infection control rates; and
- Other information such as CQC reports and information on care and comfort rounds.

The Trust measures the total number of complaints as the key metric. There is limited information on themes in this report, although themes are included in the quarterly patient experience report. The Trust also measures whether complaints are closed within the deadlines.

The Trust-wide early warning dashboard covers 15 key safety indicators such as pressure ulcers, falls and mortality. This dashboard is reviewed by CMT and the CGQC.

*Ward assurance dashboard*

In addition the Trust has developed a ward assurance dashboard which provides oversight and control of quality of care on wards through a range of safety metrics. The dashboard was sent to Divisions and Specialities to review in November 2013. The new format dashboard is being reviewed by the CQGC over the next two months.

The dashboard provides the CQGC with a useful snapshot of performance and will help identify potential 'hotspots' where quality of care may be compromised. However the dashboard does not provide early warning of potential worsening trends and thus there is scope to develop it further. The Trust should consider identifying a small number of indicators to triangulate and plot over time in order to identify trends. For example, triangulating number of incidents, complaints, level of vacancies together and plotting the trend of these over time on a graph would provide additional insight.

*Divisional and Service quality reporting*

The Trust has not yet developed integrated quality and performance dashboards at Service and Divisional level. A working group has been established and is meeting shortly for the second time to commence the development of these. The working group will include the Head of Information, Director of Nursing and Quality, Medical Director, Director of Performance in addition to one or more NEDs.

The development of these will support better alignment of key quality performance measures between Specialties, Divisions and the Board and will enhance the oversight and control of quality of care.

*Patient experience reporting*

The quarterly Board patient experience report, introduced for quarter 2 2013, includes a wide range of patient experience information such as

- Compliments
- Friends and Family Test
- Internal Patient Surveys
- Complaints
- Patient Advice & Liaison Service (PALS)

The main theme from patient complaints is staff attitude. The Trust has already used an external motivational speaker to reinforce the need for high standards of patient service. The Trust is developing a patient experience strategy and using information obtained from patients and staff about their experiences at the Trust from the 'In your shoes' and 'In our shoes' events to develop objectives and priorities for improving patient experience.

The report includes quotes for the compliments section but does not include quotes within complaints or within the 'concerns' detailed within the PALS section. At the 7 November 2013 Board meeting a NED commented that it would be useful to have information on negative patient experiences that don't necessarily turn into formal complaints as learning from these can help reduce formal complaints. The number of contacts received by the PALS team in quarter 2 was 1972, 1003 of these were 'concerns'.

Analysis of themes is limited and it is not clear from the report what specific actions are being taken to address the themes that have been identified. Clinical treatment

for example features as a common category for complaints but it is not clear what action is being taken to investigate and analyses these complaints further.

The current information in the report does provide useful insight into patient experience at the Trust. However, the Trust is aware that the quarterly quality report requires further development and this is planned alongside development of the patient experience strategy and further analysis and identification of lessons learned from complaints.

*Our view*

The quality and patient experience reports reviewed by the Board are a significant improvement on Board reports we reviewed during our January 2013 review.

Narrative explaining what action the Trust is taking to enhance quality of care and address quality issues is now included in the Board reports and the Board is sighted on a range of key quality metrics, including performance against the Trust's quality priorities.

The Trust is planning to develop quality performance dashboards at Specialty and Divisional level which are aligned to Board and Ward information and this will enhance the oversight and control of quality of care.

The Trust has addressed CQC concerns relating to oversight of ward quality performance through the introduction of a new ward dashboard. Further development of this to include trend information and triangulation of key indicators will strengthen quality governance.

Whilst the quarterly patient experience report is good practice, the Trust is aware that further analysis of complaints is required to help identify lessons to learn.

The Trust should also consider analysing the PALS concerns included in the quarterly patient experience report to provide further insight into patient experience.

## 4b – Is the Board assured of the robustness of the quality information?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Data quality*

The Board has established a Data Quality Committee chaired by the Director of Operations, which met for the first time in October 2013 and will meet quarterly in future.

A data quality group has been in operation for some time, however establishment of an Executive led Committee will provide greater focus and increase the profile of the importance of data quality.

In 2013/14 there have been two data audits, focussing on outpatients, undertaken by Data Quality Training Co-ordinator on Patient Administration System (PAS) information this year and two more are planned. The Data Quality Group reviews the results of these audits and agrees actions to improve performance where necessary.

There is evidence that data quality issues do exist and there is a risk that incorrect decisions are being made based on inaccurate data. Internal audit have conducted a review of the data quality relating to the 2012/13 quality priorities and reported this in June 2013, concluding that only limited assurance could be provided for the indicators due to inaccurate data and weak validation controls.

Whilst the Board has developed the new quarterly quality report and ward dashboard, there are no mechanisms in place that provide the Board with assurance over the quality of data included in these reports. As a compensating control Directors review board reports for reasonableness prior to being presented to Board. This approach has on occasion identified data quality issues which have then been addressed prior to the information being reported to the Board.

*Clinical audit*

Executive ownership for clinical audit has been assigned to the Medical Director, although the new interim Medical Director has only just joined the Trust.

The Clinical Audit Committee did not meet for a number of months in 2013/14 following the retirement of the committee Chair. The new Medical Director has re-established the Clinical Audit Committee, determined the exact status of progress against the plan for 2013/14 and the Trust is now focussed on completing the plan by the end of 2013/14. As at the beginning of December 2013 approximately 71% of the audits for 2013/14 had been completed.

Terms of reference for the Audit Committee and Quality Committee have been revised to ensure there is sufficient oversight of clinical audit.

Through discussion with Divisional management it is also apparent that no clinical audit findings have been reported to divisions or to CGQC in this financial year. Now the Clinical Audit Committee has been re-established the Trust should ensure that results of clinical audits are reported through to Divisions.

The 2013/14 clinical audit plan is not aligned to the quality priorities. There is only one audit linked to Trust priorities, 'Acute Kidney Injury' within the mortality work-stream.

The recent National Payment by Results Audit in September 2013 reviewed finished consultant episodes and identified some issues related to inconsistency of filing which resulted in missing co-morbidities in some cases.

The provisional figures indicated a primary diagnosis error rate of 12.4% and primary procedure error rate of 6%. This has been fed back to the department with all coding errors discussed in detail.

*Our view*

The Board is seeking to raise the profile, oversight and control of data quality at the Trust by establishing a Data Quality Committee, chaired by an Executive. Coupled with this the Data Quality Group has been meeting regularly in 2013/14 and oversees the internal data quality audits.

However, the Board is not currently receiving adequate assurance over the robustness of data quality used for decision making and performance monitoring. The Trust should consider obtaining assurance over the accuracy, validity and completeness of data quality in the Board quality and patient experience reports and the ward assurance dashboard.

The Trust has re-established the Clinical Audit Committee and should now focus on ensuring the plan is completed by the end of 2013/14. Results of audits and agreed actions should be scrutinised by the Clinical Audit Committee and provided to the Divisions.

## 4c – Is quality information being used effectively?

| | |
|---|---|
| **Current position** |  |
| **Position at 31 January 2013** |  |

*Current position*

*Governance Support Unit*

Progress in terms of establishing the GSU, clarifying and formalising roles and responsibilities has been delayed. The impact of this is that the establishment of consistent Divisional and Specialties governance reporting templates, meeting agendas and performance information has taken longer than we would expect.

There is a risk of further delays as currently there is no Head of Governance in post, until the new substantive appointment commences in February 2014.

New standardised agendas for Divisions and Specialities were used in governance meetings for the first time in October 2013. Information packs, which include information on incidents, complaints and other quality issues were provided by the GSU to Specialties and Divisions from September 2013.

The GSU now provides partially pre-populated reporting templates and information packs for Specialities and Divisions. These include information on the number of incidents, complaints, themes from complaints and risks. Divisional management we met stated that they would like greater support from the GSU both in terms of provision and analysis of information, particularly relating to lessons learned and clinical audit.

The Trust has acknowledged that progress has been slower than expected and a further restructure of the GSU has been proposed in order to ensure that the GSU is effective in supporting governance at the Trust.

*Clinical Management Team*

We observed a CMT meeting on the 20 November 2013. The meeting was chaired effectively by the Director of Nursing and Quality and there was evidence of strong and effective challenge by Divisional management. Clear actions were agreed where risks and issues were identified. For example, a risk related to lack of decontamination of mattresses which might affect patient safety was discussed and the CMT challenged the timescales presented to resolve the issue. A new action was agreed to resolve the issue within 2 days or hire mattresses as an interim measure. Whilst this issue took too long to be escalated to the CMT (See '1b: is the Board sufficiently aware of risks to quality'), the assurance and action driven discussions at CMT were effective.

*Divisional and Service information*

The new standardised process for Service and Divisional governance meetings is not yet fully established. Currently the agenda for governance meetings does not make it clear that a key element of the Divisional governance meetings is for each Service to provide an update on governance activities in the Service and any risks/issues and matters that need escalating.

Divisional management we met indicated that the newly developed governance meeting agendas are too long. This was supported by our observation of governance meetings, which overran their allotted times significantly.

The Ward assurance work (detailed within '4a – Is appropriate quality information being analysed and challenged?') has also included development of a new standardised ward information board which has been piloted on Ward 24 and is

now being rolled out across the rest of the Trust. The Board includes key information for patients and staff including:

- Photos of staff and what their role is so patients and visitors can identify what the uniforms mean;
- Information about staffing levels on shift and leadership rounding;
- Safety information that shows the number of pressure ulcers, falls and medication errors;
- Friends and family test scores; and
- Information about visiting times and how to prevent the spread of infections.

*Benchmarking and best practice*

The Trust has benchmarked performance in the Friends and Family test by comparing and highlighting the best and worse wards in the October monthly quality report. Performance is benchmarked externally for the Friends and Family test but also for infection performance metrics such as MRSA rates, where the Trust has compared performance against a group of local trusts in the region including Nottingham University Hospital, Chesterfield Royal and University Hospitals Leicester. The quarterly quality report (quarter 2 2013/14) does not benchmark performance externally and instead focuses on trends and thus potential quality hotspots.

The Trust has identified best practice to improve the ward assurance processes. For example, the Director of Nursing and Quality visited Norfolk and Norwich University Hospital NHS Foundation Trust in order learn about the Ward dashboard which was highlighted as an example of good practice during the Keogh review. The Trust has utilised this knowledge to develop the new format ward assurance dashboard.

*Timeliness of information*

The monthly quality report reviewed by the Board includes information for the previous month wherever this is available. For example, the report dated 3 October 2013 includes in-house mortality data, length of stay information, complaints information to the end of August and, pressure ulcer information and infection rate information to the end of September. This is timely based on the report date and the information was presented to Board on the 3 October 2013.

Some papers for the Board meeting we observed on the 7 November 2013 were not provided to the Board members until the night before the meeting, which did not give them time to read and consider these before the meeting commenced.

The Trust has appointed a new Director of Corporate Affairs who has begun revising the Committee structure and meeting timings to ensure that the Board receives information on a timely basis.

*Our view*

Whilst processes for standardisation of Divisional and Service governance have been implemented, further work is needed to ensure information provided to support governance activities such as governance meeting agendas and quality performance reports are fit for purpose.

It is evident that Divisional management are engaged in enhancing governance in their Divisions and within Specialties and are seeking support from the GSU in order to achieve this.

Overall the lack of stability in the GSU means that the Trust has not progressed as much as anticipated at this stage.

Particular focus should be given to the oversight and scrutiny of Specialties in order to ensure governance activities and escalation of risks and issues is prioritised.

The Trust has benefited from benchmarking quality performance externally and seeking examples of best practice in order to enhance reporting of quality information at Ward and Board level.

The substantive appointment of a Director of Corporate Affairs should help to improve timeliness of Board papers.

# 5. Recommendations

This section summarises the recommendations arising from our review. Our recommendations fall into two categories:

1. New recommendations arising from our review; and
2. Recommendations from the January 2013 Governance Action Plan that need further focus or reinforcing.

## 5.1. New recommendations arising from our review

| Ref | Report reference | Area | Action to be taken by the Trust | Suggested owner | Timeframe[1] | Priority |
|---|---|---|---|---|---|---|
| 1 | 4.3 Processes and Structures | Development of Divisional and Service Management | To support the development of Divisional and Service management, the Trust should consider pairing them with NEDs and Executives with experience of chairing committee meetings in order to provide coaching on how to chair meetings effectively. | Director of Corporate Affairs | 2 | Medium |
| 2 | 4.4 Measurement | Data quality for Board and Ward reports | Obtain assurance over the accuracy, validity and completeness of data reported in the ward assurance dashboard and the Board quality and patient experience reports. Consider requesting internal audit to conduct a data quality audit for the ward assurance dashboard and the Board quality and patient experience reports. | Director of Operations | 1 | High |
| 3 | 4.4 Measurement | Clinical audit | The Trust has re-established the Clinical Audit Committee and should now focus on ensuring the plan is completed by the end of 2013/14. Results of audits and agreed actions should be scrutinised by the Clinical Audit Committee and provided to the Divisions. | Medical Director | 1 | High |

[1] "1" = immediate action; "2" = action within three months; "3" = action within six months

| Ref | Report reference | Area | Action to be taken by the Trust | Suggested owner | Timeframe[1] | Priority |
|---|---|---|---|---|---|---|
| 4 | 4.3 Processes and Structures | Divisional and Service governance and the GSU | Finalise roles and responsibilities in GSU in terms of provision of information and governance support to ensure that Divisional, Service management and the GSU team are all clear on accountability for governance activities. Clarify and agree consistent information to be provided to Divisions and Services for governance meetings.<br>Revise the agenda for Divisional governance meetings to ensure that updates from each Service regarding risks and governance activities are more prominent and form an essential element of each Divisional governance meeting. | Director of Nursing and Quality | 1 | High |
| 5 | 4.3 Processes and Structures | Patient experience and learning | Conduct further analysis of trends and lessons to be learned from incidents, complaints and other quality issues.<br>The Trust should also consider analysing the PALS concerns included in the quarterly patient experience report to provide further insight into patient experience. | Director of Nursing and Quality | 2 | Medium |
| 6 | 4.3 Processes and Structures | Governor training | In line with the Trust's current plan, training should be provided to Governors to enable them to provide appropriate challenge and support in their role. | Director of Corporate Affairs | 2 | Medium |
| 7 | 4.4 Measurement | Ward dashboard | The Trust should consider further development of the ward dashboard to include trend information and triangulation of key indicators. | Director of Nursing and Quality | 3 | Medium |
| 8 | 4.4 Measurement | Board and Committee Papers | Ensure that papers for Board and Committees are provided to members on a timely basis to enable them to have a thorough understanding of the issues being discussed prior to the meetings. | Director of Corporate Affairs | 1 | High |

| Ref | Report reference | Area | Action to be taken by the Trust | Suggested owner | Timeframe[1] | Priority |
|---|---|---|---|---|---|---|
| 9 | 4.1<br>Strategy | Divisional risk registers | Further development of risk registers is required to ensure they are effective tools for recording and discussing risks at Divisional governance meetings. The ECM risk register is a good practice example which can be used as a basis for how the Divisional risk registers should be completed | Director of Nursing and Quality | 1 | High |

## 5.2. Recommendations from the January 2013 Governance Action Plan that need further focus or reinforcing

| Ref | Original recommendation reference | Area | Action to be taken by the Trust | Suggested owner | Timeframe[2] | Priority |
|---|---|---|---|---|---|---|
| 1 | 1 | Skills and capability of the Board | Implement the Board Development Programme as planned. The Board development programme should address how Board members seek assurance rather than reassurance. | Chief Executive | 1 | High |
| 2 | 5 | Risk Management | Provide further risk management training to Service and Divisional management in line with the Trust's plan, covering how to assess and moderate risks and how to document these on risk registers.<br>Finalise the Trust wide corporate risk register and present to the Risk Assurance Committee for regular review. | Director of Nursing and Quality | 2 | Medium |
| 3 | 9 | Quality strategy | Implement phase 2 of the Patient Safety and Quality Strategy and communicate this widely across the Trust, in line with the Trust's proposed timescale. | Director of Nursing and Quality | 2 | High |
| 4 | 13, 14 and 15 | Performance scorecards and performance reporting | Develop a Divisional and Service quality and performance dashboard aligned to the Ward Assurance tool and the Board quality report as appropriate. The Trust is already setting up a working group to consider this. | Director of Nursing and Quality | 2 | Medium |

[2] "1" = immediate action; "2" = action within three months; "3" = action within six months

| Ref | Original recommendation reference | Area | Action to be taken by the Trust | Suggested owner | Timeframe[2] | Priority |
|---|---|---|---|---|---|---|
| 5 | 18 | CIP Monitoring | The Trust should implement a monitoring process for CIPs that includes early warning KPIs for potential impacts on quality of care. Divisional management should be responsible for reviewing the quality impact of CIPs in their Divisions. Consider reporting KPIs within Divisional dashboards. | Director of Nursing and Quality and Medical Director | 2 | Medium |
| 6 | 22 | Clinical Audit | Ensure that the 2014/15 clinical audit plan is aligned to the Trust's three quality priorities | Medical Director | 3 | Medium |

# *Appendix A. - Our approach*

Our approach is designed to give the Board an independent assessment of the changes to governance arrangements following our January 2013 Board and Quality Governance Review. We have tested how quality governance is working in practice and whether this is consistent with Monitor requirements.

We have sought evidence from a number of sources:

## Document review

Our assessment consisted of an initial high level analysis of relevant documentation and data provided in order to establish the governance arrangements in place. We considered a range of documents which informed us about the quality of information being produced and how any issues are dealt with. These documents included:

- Quality Governance Framework Self-Assessment - 29 October 2013
- Board Assurance Framework as at 23 October 2013;
- Board Development Programme specification;
- Governor Induction programme evidence – April 2013;
- Risk management training evidence
- Board papers for the period May 2013 and the period September to November 2013;
- Clinical Management Team papers for August and September 2013;
- Hospital Management Board papers for September and October 2013;
- Risk Assurance Committee papers for the period September to November 2013;
- Clinical Governance and Quality Committee papers for August and September 2013;
- Examples of Service and Divisional level early warning dashboards and quality reports;
- Proposed Governance Support Unit structure – October 2013;
- Patient Experience Quarterly Report – 29 October 2013
- Integrated Performance Report to Board 3 October 2013;
- Monthly Quality & Safety Reports to Board for September and October 2013;
- Quarterly Quality & Safety Report to Board for Quarter 2 2013;
- Trust wide early warning score card - August 2013;
- Phase 1 Patient Safety and Quality Strategy;
- The Trust's strategy: Clinical Services Plan October 2013;
- Divisional Governance Meeting minutes and divisional medical director attendance audit evidence - August to September 2013;
- Standard agendas for Divisional and Service governance meetings;
- Committee governance structure chart;

- Data quality group papers for July and September 2013;
- Data Quality Committee terms of reference and minutes for October 2013;
- Internal Outpatient Data Quality Audit reports for May and July 2013;
- Governance Action Plan dated 28 October 2013;
- Example of a Service governance update report for Planned Care and Surgery;
- Divisional risk registers;
- Report to Council of Governors for training plans (November 2013);
- The Trust's Keogh action plan;
- The Trust's declaration to Monitor dated 31 October 2013;
- Ward dashboard dated September 2013;
- Clinical audit plan and progress report made to CMT in September 2013;
- Executive Accountability Framework – November 2013; and
- Patient Safety Improvement Group Terms of Reference.

## Interviews

In addition to our review of documents provided, we also conducted a number of interviews with key people at the Trust.

Our interviews aimed to assess how governance arrangements are working in practice and to ascertain the understanding, ownership and commitment to quality.

A list of the people we have spoken with is included in the table below:

| Title | Name |
|---|---|
| Chairman | Sean Lyons |
| Chief Executive | Paul O'connor |
| Head of Corporate Services/Company Secretary | Kerry Rogers |
| Interim Medical Director | Andrew Haynes |
| Director of Nursing and Quality | Susan Bowler |
| Director of Operations | Jacqui Tufnell |
| Governance Advisor | Denise Berry |
| Project Management Office Programme Manager | Yvonne Simpson |
| Patient Safety Lead and Specialty Medical Director | Simon Stinchcombe |
| Non-Executive Director, Chair of Clinical Governance and Quality Committee | Peter Marks |
| Non-Executive Director | Gerry McSorley |
| Non-Executive Director | Tim Reddish |
| Medical Director, Emergency Care and Medicine | Anne Louise Schokker |
| Divisional Nurse, Emergency Care and Medicine | Lisa Dinsdale |
| Medical Director, Planned Care and Surgery | Richard Hind |
| Divisional Nurse, Planned Care and Surgery | Liz Williamson |
| Clinical Lead, Diagnostics and Rehabilitation | Lynn Smart |

| Title | Name |
|---|---|
| Lead Governor | Craig Day |
| Head of Information | Rebecca Stevens |
| Interim Risk Manager | Shelley Watson |
| Interim Head of Governance Support Unit (until October 2013) | Sally Seeley |
| Interim Complaints Manager | Jill Faulkner |

## Observations

We also performed observations of meetings in order to see governance arrangements working in practice.

A list of the meetings we observed is included in the table opposite:

| Date | Meeting |
|---|---|
| 6 November 2013 | Emergency Care and Medicine Clinical Governance |
| 7 November 2013 | Board |
| 13 November 2013 | Risk Assurance Committee |
| 20 November 2013 | Clinical Management Team |
| 26 November 2013 | Emergency Care & Medicine – Specialty Governance meeting for Emergency Admissions Unit |
| 26 November 2013 | Planned Care & Surgery – Specialty Governance meeting for Paediatrics |
| 26 November 2013 | Diagnostics and Rehabilitation – Specialty Governance meeting for Radiology |

| Date | Meeting |
|---|---|
| 27 November 2013 | Clinical Governance and Quality Committee |