Enclosure 9

The Shrewsbury and Telford Hospital NHS
NHS Trust

Report to Public Trust Board- January 2013

Title	Quality Governance Framework
Sponsoring Executive Director	Director of Quality and Safety/ Chief Nurse
Author(s)	Director of Quality and Safety/ Chief Nurse
Purpose	To provide the Board with an updated Quality Governance Framework and identify a process for ongoing improvements.
Previously considered by	The Trust Board in March 2012 and Quality and Safety Committee in December 2012

Executive summary

The paper provides an overview of the Quality Governance Framework, the work undertaken to date on the self assessment required.

The paper proposes a collective Board validation process through which the Directors can be assured on the overall score.

Related SATH objectives	SATH Sub-objectives
We will always provide the right care for our patients	QS1. Ensure that we learn from mistakes and embrace what works well QS2. Design care around patient needs QS3. Provide the right care, right time, right place, right professional QS4. Deliver services that offer safe, evidence-based practice to improve outcomes QS5. Meet regulatory requirements and healthcare standards QS6. Ensure our patients suffer no avoidable harm

Risk and assurance issues	Positive assurance can be gained from this QGF update.
Equality and diversity issues	The report provides assurances on Quality Governance systems and processes on behalf and in support of all of our patients.
Legal and regulatory issues	This report provides assurances across all aspects of monitors Quality Governance Framework.

Trust Board action

The Trust Board are asked to **NOTE** the progress on the sub sections of the QGF .

The Board are asked to **APPROVE** the proposed process for validation and to **NOTE** the timescales for completion prior to a wider discussion in a Board workshop

The Shrewsbury and Telford Hospital NHS
NHS Trust

Quality Governance Framework
31st January 2013

1.0 Introduction

Quality Governance is the combination of structures and processes at and below Board level to lead on Trust wide quality performance. The definition of Quality performance incorporates safety, clinical effectiveness and patient experience and is measured across inputs, processes and outputs. The required external standards include, but are not limited to: legal requirements for ongoing registration with CQC and satisfaction of agreed levels of service provision and delivery against national targets and standards.

2.0 Background

2.1 The Framework

Monitor who are the Independent regulator for Foundation Trusts have developed a Quality Governance Framework which sets out 10 key questions to establish that each Trust assessed for Foundation Trust status has robust Quality Governance in place. The 10 questions are established in 4 areas of Strategy, Capabilities and Culture, Processes and Structures and Measurement.

This will ensure that:

- required standards are achieved,
- that Trusts are investigating and taking action on substandard performance,
- Planning and driving continuous improvement,
- Identifying, sharing and ensuring delivery of best-practice,
- Identifying and managing risks to quality of care

2.2 Monitors guide for assessment

Score	Risk rating	Definition	Evidence
0	Green	Meets or exceeds expectations	Many elements of good practice + no major omissions
0.1	Amber/ Green	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe	Some elements of good practice + no major omissions + robust action plans for shortfalls and proven track record of delivery
1.0	Amber/ Red	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice + no major omissions + action plans for shortfalls in early stages and limited evidence of delivery in past
4.0	Red	Does not meet expectations	Major omission in quality governance identified + significant volume of action plans required, concerns on management delivery capacity

2.3 The Trust Board has previously considered the Quality Governance framework (QGF) in Board workshops in November 2011 and early 2012 prior to formally approving a baseline QGF in the private Trust Board in 2012.

2.4 The Quality Improvement Strategy also approved in the Public Trust Board in March 2012 used the questions posed in the QGF to establish a consistent framework for the continuous improvement of Quality care and standards.

2.5 Monitor have established a process whereby the Trust Board must undertake their own self assessment of the Quality Governance Framework. The Board are asked to note that a score of 4 or worse cannot be authorized, with the overriding rule stating that no category can be rated entirely Amber/Red if the Trust was going to progress to the final stages of the Foundation Trust process.

3.0 Current position and implementing and monitoring progress

3.1 The Quality Governance Framework (QGF) process established within the Trust has been reviewed by Internal Audit with a range of actions to enhance the current process but in summary concluded that the process of developing the Trusts' framework is in line with Monitors guidance.

3.2 The QGF was updated in November and December based on key developments/ improvements since March 2012. The updated framework is outlined in Appendix 1 and was formally reviewed by the Quality and Safety Committee in the December 2012 Committee workshop .

3.3 In line with Monitors guide for self assessment, an original self assessment of the overall framework was undertaken against the March baseline and revised in December 2012, the summary of these self assessment scores is outlined in the table 1.

Table 1 Quality Governance Framework Summary

Component	RAG Score for overall component March '12	RAG score for overall component December '12
1a Does quality drive the Trusts strategy?	Amber Section 1a = 1.0	Amber Green Section 1a = 0.5
1b Is the Board sufficiently aware of potential risks to quality?	Amber /Red Section 1b = 1.0	Amber Section 1b=1.0
2a Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	Amber Section 2a = 1.0	Amber/Green Section 2a =0.5
2b Does the culture of the Board promote a quality focused culture throughout the trust?	Amber/Green Section 2b = 2.0	Amber/Green Section 2b =0.5
3a Are there clear roles and accountabilities in relation to quality governance?	Amber/Green Section 3a = 1.0	Amber/Green Section 3a =1.0
3b Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	Amber Section 3b = 1.0	Amber Section 3b =1.0
3c Does the Board actively engage patients, staff and other key stakeholders on quality?	Amber/Green Section 3c = 2.0	Amber/Green Section 3c =1.5
4a Is appropriate quality information being analysed and challenged?	Amber Section 4a = 3.0	Amber/Green Section 4a =2.5

Enclosure 9

Component	RAG Score for overall component March '12	RAG score for overall component December '12
4b Is the Board assured of the robustness of the quality information?	Amber/Red Section 4b = 1.0	Amber Section 4b =1.0
4c Is quality information being used effectively?	Amber Section 4c = 2.0	Amber Section 4c =2.0

3.4 In the March 2012 Trust Board it was proposed and accepted that Non Executive and Executive Directors paired up to undertake a validation process of the evidence against an agreed number of sections/ questions. In the analysis and review that was undertaken, some feedback indicated that the scoring for some sections could have been moved to a more positive score. However the Board are asked to note that in line with the Chief Nurse's previous advice to the Board (about the need for robust evaluation of the framework), a self assessment summary from another Trust Board along with Monitors evaluation of their position is included in Appendix 2 for information. Considering the appropriate scrutiny which Monitor will bring to the process, Board Directors are asked to undertake the same self assessment process during February 2013 and to formally return their evaluations and commentary to the Chief Nurse by the 28th February.

3.5 It is proposed that these validation returns will then be reviewed in a Board workshop in March and populated into the next update which will be taken to Quality and Safety Committee in April 2013 with a formal Board update in July 2013.

4.0 Conclusion and recommendations

The Board are asked to:

- **Note** the current position and composite score.
- **Approve** the proposed process of validation by Board Directors of this updated QGF.
- **Note** the ongoing review by the Quality and Safety Committee

Director of Quality and Safety/ Chief Nurse

January 2013

Enclosure 9

	Component	Commentary	RAG score	Composite score
(1)	**1a does quality drive the Trust's strategy?** Quality is embedded in the Trust's overall strategy	**2010/11**"Keeping it in the County" public consultation regarding service reconfiguration focused on the areas that required improvements in terms of patient safety and sustainability and focused on clinical pathways. **2010/11**- Q&S committee formed with a TOR to have an overview on Quality and as part of the assurance process to undertake a ward/ clinical area visit prior to each Committee. **2011**-The Putting Patients first document was approved at the Trust Board in March'11 and Board Performance paper has used the principles of that as the core objectives from which to report. LiA process in **2011** has used 6 large staff conversations to elicit views from staff about what needs to change and what they want to improve from both a staff and patient perspective Formal Patient safety walkabouts commenced **31st October 2011** to cover both sites once a month. Leading Improvements in Patient Safety programme and projects arising from **June 2011 and May 2012.** **2011/12** -The Quality Improvement Strategy was approved by the Board in March 2012. **2011/12** - Baseline Quality Governance Framework approved by the Board in the March 2012- Private Board **2012** -Clinical Centres have developed Centre Quality Development Plans to implement the Strategy within each clinical centre. **2012/13** - Q&S Committee have reviewed the Centre Quality Governance processes in early 2012 to ensure robust arrangements in place. Staff engagement in the development of the 2012 Quality account and QIS through staff engagement workshops **(2011/12).** External presentations of clinical priorities to LINKs and HOSC and updates in Dec to HOSC.**(2012/13)** Sharing Quality and Safety issues/ developments with staff across the Trust through monthly newsletter **2010/11** onwards Performance on Quality reviewed through monthly Quality report to Q&S committee **2011/12** and through Integrated Performance report to Board **11/12 & 12/13** Audit Committee follow up of Quality accounts and Data Quality within the audit cycle in **2012**. **2012/13** Centre performance meetings include Quality and Safety reviews		Green
(2)	The Trust's strategy comprises a small number of ambitious Trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year on year improvement	**2011/12** The Quality Improvement Strategy approved by the Board in March 2012 provides a five year strategy with a number of ambitious trust wide quality goals across the range of safety, clinical outcomes and patient experience. **2011/12** Quality and Safety Committee involvement in the planning stages of the Strategy and in Board development sessions including QIS and QA this has provided Board clarity on quality improvement priorities and an Integrated Performance report to the Board which includes Trust wide quality goals aligned to national key quality Indicators (aligned to monitor quality performance Indicators). **2012/13** The Clinical Centres have a quality development plan which again support the implementation of the Trust wide goals on quality improvements. Through the patient, staff and external stakeholder engagement with the development of the QIS, the priorities for improvement were included into the Quality account for **2012/13**. Approved by the Board in **June 2012.** **2011/12 & 2012/13** LIPS and LiA process have covered a small number of ambitious quality goals in safety and demonstrate engagement of staff in the improvement programme Patient and Public Involvement and Engagement Panel have been through a process of training in the early part of **2012 (11/12)** and are more representative of local patient groups and patient diversity – Active work programme to support continuous improvement in **2012/13**. **2012/13** The monthly Integrated Board performance paper provides high level quality indicators supported by a ward to Board metrics of clinical indicators and patient experience with Centre performance meetings review performance against goals. Centre Governance meetings provide evidence against quality KPI's		Green
(3)	Quality goals reflect local as well as national priorities, reflecting what is relevant to	**2011/12 & 2012/13** Sources for evidence are similar to QGF evidence for Q1& 2, with the QIS using the Monitor QGF questions to provide a framework approach to the Strategy and national tools in appendices to support ocal application. **2011/12** A number of staff, pt representatives and LHE partners were involved in the workshops developing quality		Green

Enclosure 9

	Component	Commentary	RAG score	Composite score
	patient and staff	improvement priorities and the outcomes of what was relevant to staff shared in poster format at a Board development workshops and feedback sessions with staff. **2012/13** CQUIN's agreed discussed with staff and patient groups locally. **2011/12 & 2012/13** CQR the forum where priorities discussed and agreed in addition to invitation to workshops Quality account developed through the above process for **2012/13**. **2012/13** PEIP involvement in an improvement programme provides the ability to reflect their views on quality improvements required as well as evaluating the impact of quality improvements and measuring patient experience. **2012/13** Centre involvement in the development of quality priorities and in supporting the ongoing process of what is relevant to staff and patients each centre has their own Quality development plan which incorporates quality improvements from the Strategy and any more clinically relevant quality goals specific to the Centre. LiA and LIPS process in **2011/ 12** as evidence of engaging staff in leading improvements		
(4)	Quality goals are selected to have the highest possible impact across the overall Trust	**2011/12** Priorities agreed in Quality accounts and through QIS **2011/12 & 2012/13** and reported on through Board integrated performance report (2012/13). Priority's based on high impact of improvement on patient safety, effectiveness and experience. **2012/13** Quality development plans support quality impacts proposed by clinicians at sub specialty level. **2012/13** Quality performance reviews with centre monitor progress with impact. **2011/12 &2012/13** LiA and LIPS process provide clear process for how Quality goals have been selected across the organisation and particularly the safety goals and impact on Mortality within the Trust		**Amber/Green**
(6)	Overall Trust-wide quality goals link directly to goals in centres/services (which will be tailored to the specific service	Evidence –x ref to questions 1-5. **2012/13** With Centre Quality development plans now in place and reviewed governance processes there are clear plans to evidence the link from Trust wide goals to centre quality improvement goals. **2011/12** Risk management Exec previously and now the Risk management Committee **2012/13** makes a clear link with high risk issues to be raised and discussed and form the link to the Board assurance framework. **2011/12 onwards** Ward to Board measures shared within the Integrated performance report provide an ability to drill down to Centre level and ward level to identify assurance Quality and Safety Committee reviewed the ward level metrics in August **2012** and the wards influencing the performance shared at the Board metrics.		**Amber/ Green**
(7)	There is a clear action plan for achieving the quality goals, with designated lead and timeframes	**2012-2017** QIS provides clarity on Goals and Quality development plans at Centre level provide the local ownership for driving the improvement. **2011/12 & 2012/13** LIPS and LiA process provided clear leads for making the improvement. **2012/13** Accountability arrangements with the Centres identified the responsibility for delivery and managed through Centre Governance meetings and Centre performance meetings **2012/13** CQUIN measures agreed have clear executive lead and clinical lead **2011/12 & 2012/13** Quality Account has clear leads identified		**Amber**
(8)	Applicants are able to demonstrate that the quality goals are effectively communicated and well understood across the Trust and the community it serves	The Quality Accounts communicate achievements for the year, which are shared / discussed with stakeholders before publication **(2010/11 &2011/12)** The trust 'Quality News' is a monthly newsletter. This has been in place since April **2009 onwards**. The newsletter can be found on the trusts website, so being used as a method of external and internal communication. **2011/12 onwards** Patient Experience and Involvement Board reviewing and involvement in quality improvement priorities and goals. **2011/12 & 2012/13** Commissioning Quality review meetings with commissioners provide robust evidence of LHE discussion on quality priorities and performance. **2012/13** Contractual meetings with Quality requirements. Feedback from meetings with the PCT on the Quality Review Process go to the Q&S Committee (ref minutes from Feb 2011, March 2011) QIS and QA –Trust involvement of HOSC and statutory patient groups **2011/12 & 2012/13**		**AMBER/ green**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2011/12 Workshops on QIS as evidenced in above sections, QA discussions in TLT, professional groups, QDP discussions in Centre Performance meetings and Quality news and "Putting pts first" briefings- share outcomes of goals. LiA and LIPS process engaged large numbers of staff in conversations about **2011/12 & 2012/13** TLT sessions enable discussion/ forum for engagement on key areas of improvement and strategy.		
(9)	The Board regularly tracks performance relative to quality goals	Board Performance report; which goes to the Board every month. This has been developed since the start of **2011**. Ward to Board measures developed in late **2011** now used at Board level to track clinical Indicators with ability to drill down to Centre and ward level Quality report to Q&S Committee on a monthly basis supports tracking of agreed clinical performance Indicators **2011/12 & 2012/13** High Risk report to Board, Q&S and HEC enables tracking of Serious Incident management and action plans for improvement. **2012/13** Centre performance management meetings track key Quality Indicators		**Amber /Green**
(10)	**1b Is the Board sufficiently aware of potential risks to quality?** The Board regularly assesses and understands current and future risks to quality and is taking steps to address them	**2011/12** Risk Management Strategy which details the processes and assurances around the management of risk. **2010/11** Datix system well established within the Trust and serious incident reporting process aligned to SHA Serious incident policy **(2011).** Trust commissioned report to review SI reporting culture **(2011)** with Quality and Safety Committee reviewing the report, action plan and subsequent reporting culture and performance management of SI investigations through the High risk report to Board (**2011 onwards**) Risk Registers in place for ward and Centre level to be able to document clinical and operational risk **2011/12** Risk Management Executive formed as a process to enable Clinical centre to discuss clinical risks from their Centre governance processes- chaired by CEO and attended by Execs which supported Board awareness and escalation onto BAF where risks compromised the strategic objectives (Board development sessions and Board papers during **2011/12 &2012/13** BAF reporting to the Board. The BAF includes any potential risks to quality. **2011/12 &2012/13** The BAF is reviewed by every meeting of the Audit Committee and lead Directors are required to attend Audit Committee at least once a year for a discussion on the risks for which they are accountable. The BAF process has been developed to include a summary of relevant key risks which should be sent to the formal committee's. **(2012/13)** The chairman of the Audit Committee presents a paper to the private Board on any issues arising from the BAF after each committee meeting. **2011/12 &2012/13** The risk register is reviewed by every meeting of the Audit Committee and Centre Chiefs are invited to attend to discuss their risks and mitigation actions Quality Report; quarterly to the Board **2011/2** & private Board Quality reports discussed particular quality risks **(2012/13).** SIs are also included in the Board Performance report as well as High risk report to Private Board **2011/12 &2012/13**. The Risk Management Executive Committee provides a report to the Board (private session)**2011/12 &2012/13**. Risk management Committee revised TOR to support improved process of escalation onto BAF at Board discussions **(2012/13)**		**Amber/Green**
(11)	The Board regularly reviews quality risks in an up-to-date risk register	Formal sub Board Committee's TOR include the review of appropriate risks to that Committee **(2012/13)** Risk Management Strategy, detailing the processes and assurances around risk is updated on a regular basis and approved by the Board. Next review date is March 2013. Risk management Committee TOR revised in **late 2012** to reflect Executive lead review with Non exec involvement of serious risks and the BAF risks prior to update at the Board with all examples of evidence from Q10 to support this section. Centre governance meetings well established and include new and established risks**(2012/13)**		**Amber/ Green**

Enclosure 9

	Component	Commentary	RAG score	Composite score
(12)	The Board risk register is supported and fed by quality issues captured in centres/service risk registers	BAF Board papers identify the risk metrics, the risks and level of risks that pertain to the Trusts strategic objectives and the changes since last review and what are new onto the BAF **(2012/13).** The x-ref with evidence in Q 10 to this point support how the risks are reviewed at ward level to Centre level. Review of implementation of action plans reviewed in Centre performance meetings **(2012/13).** Q&S Committee –TOR have been changed to reflect the review of risks relevant to the Committee **(2012/13).** High Risk report presented in each private Board as well as the number of SI's in the public Board **(2011/12 &2012/13)** Risk Management Executive Committee, reported to the Board in the private session. This made a clear link between Centre risk registers and corporate risk register and the escalation and mitigation process. TOR revised (x-ref to section 10&11) Minutes from previous Risk Management Exec demonstrate detailed review of each centre and support development of understanding on risk management, the risk registers include clinical risks and risks highlighted by gap analysis (eg compliance with NCEPOD recommendations (**2011/12 &2012/13)**		**Amber /Green**
(13)	The risk register covers potential future external risks to quality(e.g. new technologies, competitive landscape, demographics, policy change, funding, regulatory landscape as well as internal risks	**2011/12**- BAF taken to Board demonstrates the links with corporate objectives and the risks and mitigation for those risks. The Strategic Plan process looks at any new developments and is reviewed through Risk management Committee (revised TOR in **Nov '12**) to ensure regular review of future external risks as well as current risks to the BAF. **2012** Formal Trust Board sub committee's TOR include the review of their risk register. Reviews of risks on the risk register take place on a regular basis so any new developments/ new assurances/ potential new risks are considered. **2012** Board paper on BAF includes changes to Board level risks and identification of new risks against corporate objectives		**AMBER**
(14)	There is clear evidence of action to mitigate risks to quality	**2012/13** Quality Impact assessments demonstrate the process of reviewing the mitigation of risk with CIP programme and reconfiguration processes. Q&S Committee have reviewed this QIA process **(October 2012**) with a high level summary of the outcomes of those reviews and commentary. Action plans on 4Risk for risks that affect quality and action plans as outcomes of Serious Incidents reported on STEIS. **(2011/12 &2012/13).** RCA process and formal reviews from Ophthalmology reviews which included patients in those reviews where they challenged practice and involved in actions to mitigate risks **(2011/12 & 2012/13).** Private Board papers identifying wards where concerns have been escalated when evidence of concerns about quality, demonstrating approach to mitigate risk and improve quality (**July 2012, August 2012 and Sept 2012).** Ward to Board metrics and high level KPI quality indicators used at Board, centre and ward level to understand risks to quality and Centre performance meetings review the outstanding actions to improving quality from SI events **(2012/13) 2011/12 &2012/13** High risk scrutiny meetings review actions for improvement where previous SI or complaint issues and also triangulate complaints, SI and Safeguarding issues to ensure trends and themes that may compromise quality are identified and Centres have developed their processes for tracking in their Governance meetings **2012/13 2011/12 &2012/13** Clinical audit has tracking system fro recommendations reported to Clinical audit committee chaired by Associate Medical Director		**AMBER**
(15)	Proposed initiatives are rated according to their potential impact on quality(e.g. clinical staff cuts would likely receive a high risk assessment	**2011/12** Quality Impact assessment workshops held in Dec 2011, Jan-March 2012 to support Trust wide managers, clinicians and senior nurses/ AHP to be able to carry out QIA process and template. **2012** CIP meetings- agenda and minutes demonstrate the PMO requests for QIA process to be undertaken Q&S review of QIA undertaken during summer 2012 with recommendations for which needed Board level discussion **(October 2012)** Timing of QIA needs to be at front end of CIP process not mid- late year and more detail completed prior to MD/Chief Nurse review and sign off		**AMBER/**

Enclosure 9

	Component	Commentary	RAG score	Composite score
(16)	Initiatives with significant potential to impact quality are supported by a detailed assessment that could include: "Bottom-up" analysis of where waste exists in current processes and how it can be reduced without impacting quality (e.g.Lean)	System reviews included in CIP programme where the schemes are identified as supporting programmes, such as PSAG and HSAG and these have been reviewed through the QIA process A range of Quality Impact Assessments demonstrate the bottom up detailed analysis		Amber / RED
(17)	Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ration, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality)	**2011/12** Board Quality reports on Mortality data- with regional benchmarks The publication of Dr Foster allows benchmarking for a number of quality indicators.**2011/12 ands 2012/13** **2011/12 & 2012/13** Acute Trust Quality Dashboard shared in Quality and Safety Committee provides opportunity to benchmark but this could be used more routinely within the Committee. **2012/13** Safety Thermometer process established in April 2012 as part of the regional CQUIN improvements which also enables benchmark of performance against regional and national figures. Ward to Board system from HEFT "Test your care" has been purchased by the trust in **2011**. This allows benchmarking with around another 12 trusts (Ward to Board) Ward to Board indicators proposal presented to the Q&S Committee, **August 2011.** Staffing review (**completed Feb/ March 2011)** using data from across 8 trusts. Board report on SI benchmarks **(2012)** CQUINs – **2012** reported in Quality News and Board Performance report Mortality Review, with support of the Dr Foster team – comparing to 6 other hospitals. **June 2011** Board paper (private session). OPD/ A&E/ Maternity benchmarks for Dept to Board metrics will commence in **2012/2013**		AMBER
(18)	Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints)	Review of staffing commenced in **2010/11** which was taken to Q&S and then reviewed in the Board which increased staffing levels by over 70 wte across nursing and medical staffing figures. **2011/12** PWC review of staffing provided triangulated staffing figures, with current baseline of staffing, the professional view of trained and HCA staffing required for covering shifts. Signed off staffing figures by Matron and ward managers. **2012** On costs and maternity process discussed and assurance process with each ward establishment undertaken by Workforce Director, Chief Nurse and Deputy Chief Nurse. The QIA was undertaken and rejected on the basis of 18.5% oncosts as clear from 2012/13 PWC process that could not effect savings with minimal on costs of 18.5% and this changed to be an acceptable level. Baseline nurse pt ratio undertaken prior to the PWC review and this now needs to be updated. **2012/13** Areas outside the wards which went through the PWC review need further work as still remain on 18.5% on costs and this needs to be aligned in budget setting for **13/14**. **2011/12** High Risk report to the Board in private session identifies SI's and RCA process makes links to staffing issues if relevant. **2011/12 & 2012/13** Complaints are included in the monthly Board Performance report and along with ward to Board "Test your care" in the Quality report. **2011/12 and 2012/13** At operational level, SI, complaints and safeguarding referrals are triangulated to provide themes		AMBER

Enclosure 9

	Component	Commentary	RAG score	Composite score
		but also ward related concerns which may indicate staffing concerns if relevant. **2012/13** CQUINs – reported in Quality News and Board Performance report		
(19)	The Board is assured that initiatives have been assessed for quality	**2012** Quality and Safety Committee have reviewed a summary of all the QIA assessments in the October 2012 Q&S Workshop. The NEDs evidence of challenge at Quality and Safety Staffing review discussed and challenged in Q&S and at Board **2011/12** Centres went live in **October 2011** and Governance processes re initiatives assessed for Quality has commenced with workshops held in December and January and examples provided on completed QIA on bed reconfiguration, escalation ward and ward establishment review. **2011/ 12**. Centre Quality performance review's established in **2012** and including Quality performance reviews. **2012/ 13** Q&S committee have received presentations from Centres to understand Governance processes established to ensure all processes,(complaints/ SI's, safeguarding etc) Board yet to receive a direct report only via Q&S		AMBER
(20)	All initiatives are accepted and understood by clinicians	Over 100 clinicians trained for Leading Improvement in Patient Safety programme in **June 2011**, with clinicians leading teams in the improvements. Board paper supporting LIPS future programmes (**January 2012)** TLT has been established since **2011/1272012/13** to ensure Clinical leaders and Exec team are working through initiatives. **2011/12 &2012/13** FCHS project had Centre Chiefs involved and detailed clinical engagement in the clinical pathways as well as workforce figures. Clinical forum and GP's /LHE clinicians working through clinical pathway outputs. Centre Chief and clinicians involved in reconfiguration consultation **2010/11** and **2011/12** **2011/ 12** HEC is a forum to ensure that any initiative should be reviewed and approved by the Centre Chiefs and Exec team. Agenda items are put into sub sections for approach, approval or for info as well as quality and safety. • Hand Hygiene Compliance – monitored by IPC Team. **July 2011** minutes public Board. • Compliance is reported through HEC with Centre Chiefs as members with DIPC part of core Peer group.**2012** • Infection control attendance at ODG to reinforce practice refinement where required **2012** • HCAI Annual Report **2010/11**, including Q1 Infection Control Report. • WHO safer surgery discussions re compliance and performance management **2011**. • VTE compliance reported and discussed in multiple forum. • High risk papers and discussion on reporting Serious Incidents (monthly **2011/127 2012/13**.) • Safeguarding annual report to Board but not to HEC need to consider process to ensure engagement Transitional team meetings co-chaired by Director of Operations and Value stream lead (VSL) for unscheduled care**.** **2011/12**		Amber
(21)	There is clear subsequent ownership (e.g. relevant Centre Chief)	Devolution and cooperation process with management of change to implementation has developed clarity on accountability arrangements, defined through JD's and structures and signed accountability documents. **(2012/13)** **2011/12 & 2012/13** Development sessions for the Clinical centres- through TLT and HEC provide clarity on ownership and accountability. **2011/12 & 2012/13** centre performance meetings and HEC focus and enable ownership and accountability arrangements. **2012** Q&S review of Quality governance processes to ensure centre arrangements robust		Amber
(22)	There is an appropriate mechanism in place for capturing front-line staff concerns, including a	**2011/12** The trust has a Whistleblowing Policy. Notice in **October 2011** payslips on the Whistleblowing Policy. **2011/12 & 2012/13** Professional forums- Ward managers/ senior nurses/ HEC and medical forum to debate and discuss any concerns		AMBER / GREEN

Enclosure 9

	Component	Commentary	RAG score	Composite score
	defined whistleblower policy	**2010/11, 2011/12 &2012/13** Induction includes Whistle blowing. Datix reporting, Quality reviews- informal handover reviews by Corporate nursing, PEIP reviews on wards including staff engagement discussions with commissioners, senior staff **2011/1272012/13**, pulse check process (2011) with LiA process and staff engagement workshops (**2010/11)**		
(23)	"Initiatives" impact on quality is monitored on an ongoing basis (post implementation)	X ref to 14,15,16 &19 evidence		**AMBER**
(24)	Key measures of quality and early warning indicators indentified for each initiative	**2011/127 2012/13** Board Performance report providing feedback on performance deterioration where applicable with Monitor risk rating being managed through PMR report to SHA and declaration of risk score being formally reported. **2011/12 7 2012/13** The BAF details risks around key strategic/ operational risks and presented at the Board at least Quarterly. **2011/12** Risk management Executive Committee provides a formal forum for sharing clinical and operational risks as measure of early warning of corporate/ serious concerns. 2012/13 TOR revised to reflect risks at high level and direct correlation to BAF and then reflected in Board BAF reports **(Nov 2012)** **2011/12 & 2012/13** Centre balanced scorecards – noted through Centre monthly governance meetings and metrics shared. **2012** Q&S committee in August reviewed a range of ward level quality indicators from the Board level report and ability to drill down from Trust Board reports. **2011/12 &2012/13** high risk scrutiny meetings provides an operational level review of complaints, Serious Incidents and safeguarding as well as operational performance which enables early warning of trend and themes as well as wards of concern **2012** Quality report reviewed in CQR and Q&S Committee reviewing trends and themes and early. Quality performance review meeting identifies ward to Board metrics used as key measures for care delivery at ward level. **2011/12 &2012/13** Formal reviews- external and Internal can be evidenced through Exec team papers, Quality and safety Committee and Board **2011/12 & 2012/13** LIPS programme includes use of measurement for improvements **2011/12** Health assure system will give ward to Board view of compliance with CQC requirements		**AMBER**
(25)	Quality measures monitored before and after implementation	Formal processes need to be in place whereby agreed quality measures are identified in proposal papers/ business cases formed through Quality Impact assessments. The QIA needs to be part of the TOR of the project management process and formally reviewed at all stages to implementation and post implementation Chief Nurse and Finance Director to establish ongoing monitoring of CIP schemes against the Quality Impact assessments undertaken by clinical teams		**Amber /RED**
(26)	Mitigating action taken where necessary	**2011/12 &2012/13** The Risk Register and the BAF include details of mitigating actions. **2011/12 &2012/13** Local risk registers demonstrate mitigating actions. **2012/13** –Centre performance meetings review RCA outstanding actions plans to track mitigating actions. **2012** QIA process which commenced mid 2012 provides mitigating actions to support risk score in PID and in the QIA which is a post mitigation score. **2011/12 &2012/13** Compliance to national alerts demonstrate mitigating action with outstanding alerts reported in Quality report monthly. **2011/12 & 2012/13** SI or Datix management records demonstrate mitigation and further actions to mitigate- RCA reviews		**AMBER**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		look at all aspects of practice and put in clear actions to mitigate and use Ophthalmology RCA as evidence to discussion at private Board. The Royal College report as conclusion of review regarding mitigating action **(2012)** Risk management Executive meetings formally review Centre risk registers and discuss and agree mitigating action required and now reviewed through revised TOR for Risk management Committee **(2012)** ***Ref back to 24,25 and cross ref evidence and commentary***		
27	**2a: Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?** The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review (either through participation in audit Committee or relevant quality-focused committees and sub-committees)	**2010 &2011** The Audit Committee are part of the formal sub committee structure for the Trust Board with a role to provide challenge through review of Directors in relation to BAF risks and Centre Chiefs in relation to risk register. The audit Committee carries out regular reviews of effectiveness through TOR and alignment with chairs of other formal sub committee chairs. TOR of all sub committees reviewed in **2011 and 2012**. Quality Accounts published following Trust Board approval **2010, 2011 and 2012** Q&S Committee; which has been in place since November **2010** ensures that adequate focus on Quality and safety and assurance on the systems and processes established through operational governance, evidence of assurance gained by the Committee taken through Quality reports using ward to Board measures from late **2011/12** and **2012/13-** deep dive into ward level indicators in August 2012. Presentations made to Q&S workshop in April, June and August to test out Centre Governance processes. Three NEDs sit on the Q&S Committee and monthly key points from committee made to Trust Board. Work programme for Q&S committee provides overview of key issues being reviewed.. **May 2012** The Q&S Committee, along with the Board and other sub-committees carry out an annual review of their performance. Review of the effectiveness of the Q&S Committee undertaken at the **June 2011** meeting. (**ref June 2011 Q&S Minutes)** Review of TOR and annual review of performance carried out in February and formalised through Committee in **March 2011 & 2012 (May)** There is a NED lead for Quality and Safety which has remained consistent since formation of committee in **Nov 2010**. Formal review of TOR, annual performance/ self assessment undertaken. Board Development Programme paper went to the **June 2011** Board. Quality Governance baseline assessment undertaken and approved in **March 2012** Trust Board. Quality Improvement Startegy provides and framework for continuous improvement=- approved at Trust Board in **March 2012,** with Centre Quality development plans approved through Centre Governance processes and shared with Q&S committee in mid **2012.**		**Amber/Green**
(28)	The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board	**2011/12** Board profiles included in the IBP detail the capabilities and experience. –need updating to reflect full range of experience once new chair and non exec in place **2010/11 &2011/12** & current The NED lead for Quality and Safety and supported by other non exec colleagues with HR experience, one clinical/ professional background to provide a broad range of skills. **Current** An (NED) is the older person's dignity champion and provides challenge at Board and Q&S in tracking undertakings and actions. **2011/12 & 2012/13** The Board Development Programme reflects time to review roles and accountability but also needs to reflect Board training as well as development. **2011/12 & 2012/13** As a trust Board an annual self assessment is carried out. Formal sub Committee's have Non- Exec chairs and Q&S have reviewed their TOR and refined those for attendance and membership and also built into the programme a self assessment which is due for formal ratification at **March '12** committee. Both executives and NEDs have appraisals which identity any weaknesses/ areas for development. Need to agree process for the principles of this process to come back to Board development in line with training needs assessment.		**Amber /green**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2011/12 Executive Directors are members of HEC and Executive risk management Committee and therefore have greater exposure to clinical, quality, risk discussions to support discussion at the Board. **2012/13** Portfolio of Clinical Executive Directors cover the full range of quality and safety including clinical outcomes and Clinical effectiveness and opportunity with new medical Director being recruited to consider best fit for clinical experience and capabilities. **2012/13** Re-assessment of level of working of Q&S committee with support of third tier committees to support detailed review and enable assurance level of working for Q&S		
(29)	Board members are able to: Describe the Trust's top three quality related priorities; Identify well -& poor-performing services in relation to quality, and action the Trust is taking to address them	**2012** The Quality Improvement Strategy sets out year on year priorities, which include year on year objectives. Quality development plans in **2012/13** support the implementation of the Strategy objectives plus centre specific objectives agreed as a priority by the Centres. **2011/12 & 2012/13** Quality account process engaged staff as well as the QIS process to consider clinical priorities for improvement. **2011/12** The workshops contributing to the QIS have supported wider staff and patient involvement in setting priorities. A programme for development of QIS was taken to the **March 2011** Board. Update taken in November **2011/12 & 2012/13** Workshop outputs describe priorities and are supported by known risks or issues reported to Quality and Safety Committee through Quality report and papers on specific issues. **2011/12 &2012/13** Risk management executive Committee provide the escalation process from Centre risk registers to corporate risk registers and BAF where required. The follow up and testing at least quarterly of corporate risks and known clinical priorities needs to be explicit on private Board and Board development and then described in BAF, which is now explicitly linked in Risk management Executive, chaired by CEO. (**Nov 2012)** Trust Board reports to Private Board outlining clinical areas of concern along with Quality Improvement framework and level of concern along with process for gaining assurance after programme for improvement in place. **(July, August and September Board 2012).** Quality and Safety Committee review of ward to Board level indicators for the wards of concern in **August 2012** QIA process to review mitigating actions to risks **2012** High risk report outlining high risk reports and Quality reports with trends and themes. Intergrated performance report to Board from **Non '12** **2011/12 & 2012/13** Board Performance report and Quality and Safety committee will provide high level assurance or escalation of poor performance supported by HEC and executive risk management committee.		**Amber /green**
(30)	Explain how it uses external benchmark to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures)	**2011/12 & 2012/13** Dr Foster review system enables benchmarking on a range of issues **2011/12 &2012/13** Ward to Board system purchased by the trust allows benchmarking with around another 12 trusts using a clinical dashboard approach ***"Test your care"*** is now used by every ward and reported at ward, centre and Board level and will spread to other clinical areas in late **2012/13** (OPD, A&E and Maternity) **2011/12** Mortality review group led by Medical Director with Associates leading Centre processes. **2011/12 &2012/13** Gap analysis carried out against Confidential Enquiries led by Medical Director as well as Gap analysis of NICE guidelines Quality Observatories for acute Trust shared with all providers- **2012/13** monthly **2011/12** Specific examples are Dependency and Acuity through Safer Nursing care which allows us to benchmark clinical indicators and staffing resources. **2011/12** Trust Board paper to Private Board reviewing benchmarking against Serious Incidents provided an initial view with an additional benchmarking process being undertaken in late **2012/13**		**AMBER**
(31)	Understand the purpose of each metric they review, be	Board performance report based on agreed Putting patients first Strategy agreed in March **2011**. Metrics discussed and agreed that refinement needed and made in **2012** and further refinement made through PMR and		**AMBER**

Enclosure 9

	Component	Commentary	RAG score	Composite score
	able to interpret them and draw conclusions from them	Integrated performance report to the Board **2012/13** **2011/12 &2012/13** Executive and non executive agreement on ward to Board metrics and safer nursing care tool for metrics at clinical level. Provides an ability to review metrics at high Board level or more detail at Centre and ward level. Non exec testing of metrics in Q&S committee workshop and utilised in pre-Committee visits to wards (**2012/13)**		
(32)	Be clear about basic processes and structures of quality governance	***2011/12*** The Quality Improvement Strategy approved in March 2012. **2012/13** Clinical centres have a centre quality development plan to support implementation of the Quality Improvement strategy along with Quality account priorities developed with staff. **2012/13** Accountability agreements made with each centre covering quality, performance and finance. **2012/13** Centre performance meetings where quality, performance and finance reviewed together to ensure key challenges discussed and mitigating action taken where required. **2010/11** Formal sub Committee structure amended to reflect quality and Safety focus with HEC committee formed to ensure that Clinical Centre Chiefs provided the clinical leadership alongside the Executive team (**2011)** **2012/13** Revised committee structure to refine working group reporting arrangements and a Clinical Governance Committee led by medical Director being formed in late **2012/13** to support Q&S to be working at a higher level to gain assurance 2011/12 (March 2012)Baseline QGF approved at the Board- key questions of governance in QGF used as a framework in the Quality improvement Strategy with systems and processes/ tools to support improvement.		**Amber/green**
(33)	Feel they have the information and confidence to challenge data	**2011/12** Q&S committee have received a detailed Quality report providing information on key quality indicators. Board level report from chair of Q&S provides key themes. **2011/12 &2012/13** Performance report to the Board provides high level data on quality indicators with Q&S members of the Board understanding the detail behind this to question trends and themes. **2012** Integrated performance report develops KPIs in line with PMR and provides thresholds and variance reporting to provide high level assurance. **2011/12 &2012/13** ward to Board measures provide ability for the Board level data on quality improvements and an ability to drill down where required and this has been tested by Q&S committee and used when visiting wards before committee.		**AMBER**
(34)	Be clear about when it is necessary to seek external assurances on quality e.g. how and when it will access independent advice on clinical matters	**2010/11** External assurance sought for the review of RTT and backlog issues when the Trust Board became aware of serious concerns. Used position to then work through clinical risk issues whilst reducing backlog. **2011/12** External commissioned review of MAU in Shrewsbury following concerns about number of incidents and concerns, leading to a report, recommendations and action plan for improvement. **2011/12** Benchmarking system from HEFT has been purchased by the trust. This allows benchmarking with around another 12 trusts " Test your care" high level clinical indicators provided at Board each month. **2012/13** commissioned the Royal college of Ophthalmology to undertake a benchtop review of the systems and processes in place for cataract surgery and then on site visit to conclude review providing Board and LHE assurance on standards in place		**Amber/Green**
(35)	Applicants are able to give specific examples of when the Board has had a significant impact on improving quality performance (e.g. must provide evidence of the Board's role in leading on quality)	**2010/11** Independent advice commissioned in relation to Board concerns on backlog and clinical risk impact on patients waiting beyond national waiting times leading to Board level review of system and process improvements in booking and scheduling. **2011/12** Board endorsement of LIPS and LiA programmes provides specific examples of Board focus and resources to enable improvements in quality and safety (Protected meal times). **2011/12 & 2012/13** Board focus through LIPS and performance management provides evidence of improvements in Mortality figures (crude death rates by 10%) and achievement of VTE targets **2011/12 & 2012/13** –Quality Improvement Strategy developed with staff and patient engagement developed for a 5 year quality improvement strategy and Clinical centres have developed supporting quality development plans supporting the implementation of the Strategy and local application of sub specialty improvements.		**Amber/Green**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2011/12 &2012/13- Introduction of ward to Board metrics, comfort rounds and ward reviews resulting in improved focus on quality at ward level and improved pt experience		
(36)	The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained	**2011/12& 2012/13** The Board conducts an annual self assessments and the TOR for each of the Board sub committees' has the requirement to undertake an annual self assessment, review its work programme, note end of year process. Q&S committee May 2012. F&P committee? April/ May 2012.		**AMBER**
(37)	Board members have attended training sessions covering the core elements of quality governance and continuous improvement	**2011/12 &2012/13** Board development sessions held on a regular basis covering Quality Improvement Strategy sessions, Integrated Business Plan, Quality accounts, Quality Governance framework sessions as well as focus on LIPS, reconfiguration and efficiency improvements.		**AMBER**
(38)	2b: Does the Board promote a quality-focused culture throughout the Trust? The Board takes an active leadership role on quality	The Board reviewed the formal members roles in light of clinical concerns raised in **2010** and identified a revised Executive portfolio to reflect and promote quality culture. CEO held staff meetings and consultation on the causes for staff concerns across organisation in **2010** and revised organisational structure to reflect need for clinical leadership (**Oct 2010).** Devolution and cooperation report published in **October 2010** to form Clinical centres and provide Clinical leadership to drive quality A lead Non executive Director for Quality and Safety Committee formed in Nov **2010** along with an additional Non executive Director to provide clinical challenge and assurance. Following the Frances Report the Board took actions to ensure quality was given relevant focus at Board meetings with the Board receiving a report on benchmarks against external reviews nationally **2011/12** Monthly Quality news focusing either CEO, Chief Nurse and Medical Director **2010/11 &2012/13-** Newsletters in "Putting pts first". CEO briefings to staff and public/ patients on Quality issues and starting a transparent approach through leadership team at the Board **2010/11 &2011/12** CEO commissioned LIPS programme locally for over 100 staff (**2011)** in first cohort and 30 further staff in cohort 2 **(2012)** Revised Board agenda to reflect adequate time for Quality and Safety as well as Q&S committee. **2012** Centre governance arrangements tested out by Q&S committee to gain assurance. **2011/12 &2012/13** Revised accountability arrangements with formal sub committees that enable quality from ward to Board reflected through each agenda and minutes. **2010/11 &2012/13** LIPS programme and LiA process provide a strength of leadership from CEO and supported by Executive lead on quality/ safety issues **2011/12** HEC providing a forum for Executive leadership and Centre chiefs as clinical leaders to form a formal sub group to the Board Quality Improvement Strategy approved by the Board in **March 2012** after extensive staff and patient consultation followed by the Centres producing annual quality development plans for **2012/13** which will then be incorporated into business planning processes each year.		**Amber/Green**
(39)	The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations)	**2011/12** Formation of the Clinical leadership through Devolution and cooperation to ensure lessons from the Francis Enquiry followed through. **2011/12** Reviews of the impact of the Mid Staffs report/ enquiry undertaken by the trust. **2011/12** Quality Improvement Strategy workshops held in Nov'11, Dec'11 and January'12 involved staff and patients in what their views were for quality improvement, outcomes from those workshops have been fed into objectives and text within the Strategy. 5 year Quality Improvement Strategy approved by the Board in March **2012** **2011/12 &2012/13** Publication of Quality account and process of sharing and testing out priorities with external		**GREEN**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		stakeholders as well as internal stakeholders to be proactive with approach to Quality improvement. **2010/11 &2012/13** LIPS process took a proactive approach to improving the safety culture to prevent any concerns raised in the Francis report. **2011/12** LiA process again enabled staff conversations about issues of concern, actions they wanted to take to make improvements and then the Blue print to provide an alliance between Board/ Exec views on quality improvements and staff views. The programme focused on implementing the enabling projects and early wins. **2012/13** Clinical leadership programme commenced in partnership with Warwick University **2011/12 &2012/13** Patient experience and involvement panel (PEIP) developed to provide user and pt rep involvement in quality improvements- active work programme since beginning of 2012 **2011/12 & 2012/13** Centre performance meetings, HEC and ODG provide clinical forums where concerns can be raised and mitigation agreed or concerns escalated. Executive Risk Management Committee enables Centres to raise clinical risks formally and peer review by other Centre Chiefs and Executives enables either escalation to corporate risk register or mitigation with controls back to the Centres. **2012** Now revised to risk management committee to align review of high risks with Board assurance framework, chaired by Chief Executive. PCT and SHA review of clinical performance in **July 2011** to follow up on concerns, monthly review of improvement action plan since then with PMR reviewed following each Board Ward profiles of concerns as arisen shared with University along with a developed and agreed soft and hard intelligence flow chart to raise concerns which the University developed after the Francis Enquiry. Workshop in **Nov 2011** agreed way forward for proactive management. Senior support resources provided from the University to support improvements in ward areas. **2011** Requests from Commissioners relating to recommendations made in Francis report. Quality report being shared with Quality review meeting- announced and unannounced visits made within the Trust. Quality Improvement frameworks introduced in **2012** to support ward improvements have involved Commissioners, Education colleagues and patient representatives to provide the Board with a level of assurance ***2011/12*** Quality Governance Framework developed for Board review of systems and processes that needed to be put in place to support appropriate Governance arrangements for Quality improvement but also to ensure that the organisation has embedded the Francis enquiry principles ***2011*** Regular reports to the Board on 'National Reports and Recommendations' which includes updates on actions against outcomes from the Mid Staffs enquiry Francis Report updates to the Board and resulting actions.		
(40)	The Board regularly commits resources (time and money) to delivering quality initiatives	Board Development Programme paper went to the **June 2011** Board. Funding supporting LIPS programme in **2011** and **2012.** **2011/12** LiA programme funded to support staff engagement in improvements. **2012/13** –Clinical leadership programme in conjunction with Warwick University		**AMBER / GREEN**
(41)	The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members)	**2010/11** Board revised portfolio's to enable executive portfolio's to actively engage in delivery of Quality improvement. **2010/11** NED lead for Quality and Safety Committee formed in Nov '10 to actively engage in quality improvements. **2010/11** onwards An NED is the older person's dignity champion and Dementia lead. **2010** Additional Non exec Director recruited onto the Board to reflect clinical background and knowledge. **2010/11 & 2011/12** CEO led the County wide "Keep it in the County" taking a strong position on transparency and openness about care provision that was of concern and commitment to act on these and make improvements. **2011/12** LIPS and LiA are clear examples of Executive leadership to improve Quality as well as clinical profile and ward review process leading to ward to Board clinical indicators for improvement.		**AMBER / GREEN**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2011/12 &2012/13 Executive leadership in developing QGF and QIS to enable strong clinical leadership at clinical Centres to take forward improvements over the next 5 years. **2012/13** Clinical Centres asked to produce quality development plans to support implementation of the QI strategy at centre level and produce local priorities at sub specialty level. 2012/13 Centre performance meetings including quality performance as well as finance and performance.		
(42)	The Board encourages staff empowerment on quality	Board and Committee structure changes following the Francis report, introduced from **September 2010.** Quality and Safety Committee formed in **Nov 2010** and Centre leads attending committee to present clinical Governance arrangements during **2012** Revised executive portfolio's from **October 2010** to reflect increased focus on quality performance **2010** Devolution and cooperation provides basis to develop and empower staff on quality improvement. Clinical centres developed and went live during **2011/12** **2011/12** Management of change process enables clinical centres to form providing a clinical leadership framework. **2010/11 &2011/12** Transitional Leadership Team (TLT) formed to support confidence and development of core management and leadership development and agreement of Exec buddy system to support any further development. **2011/12 and 2012/13** Leadership Academy developed with leadership programmes and coaching courses to support development of senior staff and centre Chiefs. Revised systems and processes to review clinical indicators **2011/12 &2012/13** Ie ward to Board assurance Comfort rounds Quality rounds and checks 2012-12-17Patient reviews Executive Patient safety walkabouts introduced in **2011/12** Dependency and acuity undertaken in January and **June 2011** Quality performance meetings established to review centre clinical performance and track improvement. Positive involvement during **2011&2012** through LIPS, LiA process to engage in quality improvements and safety improvements and support. **2011/12** Matrons/ senior nurses/ AHP's non clinical staff actively engaged in QIS process and Centre Chiefs engaged with objectives for the QIS. **2011/12** HEC and ODG are forum where staff can raise / bring papers for Quality Improvement or raise concerns which need formal consideration for approach/ agreement or for information empowering them to consider and share approach / concerns Band 7 and NMF are professional forum where system and processes for improvement discussed and agreed and agreed actions for tools to be used in wards/ Depts CEO briefings and TLT where clinical staff can raise issues and involve themselves in key issues		Amber/Green
(43)	Staff are encouraged to participate in quality/continuous improvement training and development	LIPS programme commenced in **June 2011** which provided tools, training and support for continuous improvement and **May 2012**. Board have approved further 2 training courses on site for clinical and non clinical staff to support continuous safety improvement which will include support and mentorship from cohort 1 to support and share learning. **March 2012** The Quality Improvement Strategy was approved after significant involvement of staff and patients in the discussion about quality improvement (with workshops held in Nov, Dec '11 and then January 2012). A programme for development was taken to the **March 2011** Board. A revised position taken in November 2011 Board and then process commenced. **2011** LiA process has also engaged staff in making improvements to quality and to staff conditions/ morale, staff being encouraged to think of small improvements that would support improved conditions to staff and patients as well as systems and processes. **2012** Centre audit and governance processes tested out through presentations to Q&S committee during 2012 and		Amber/Green

Enclosure 9

	Component	Commentary	RAG score	Composite score
		Centre performance meetings focus on quality performance as well as activity performance and finance. **2012** Leadership academy will support learning and growth but formally the Organisational development Strategy and workforce Strategy will review the needs to support this are A number of Clinical audit workshops have been held with over a 120 staff (what period is this) and the clinical audit forward plan is developed in conjunction with clinical leaders		
(44)	Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment)	**2011 onwards** Datix reporting and comparison with NPSA/ NLRS with other Trusts as one method of staff culture of reporting- High risk report to Private Board and HEC provide a regular review of the reporting culture. External review of SI reporting process commissioned in **January '11** and reported to Board in **March 2011**, subsequent reports to private Board and Quality and Safety and HEC define ongoing monitoring and updates on progress of review and action plans have been put in place to increase awareness of triggers for SI and Never Events. **2011/12** Clinical leadership providing improvements in WHO safer surgery. 2011/12 &2012/13 Clinical Centres and safety leads holding robust RCA processes and transparent documents shared internally and externally for actions for improvement. **2011/12** Never Events discussed in HEC, Q&S and Board to agree actions and consider balance of reporting and holding to account and ensuring actions followed through and tracked. **2011/12 & 2012/13** High risk scrutiny weekly meetings brings together senior nurses/ managers to review new complaints, SIU and safeguarding and any other issue that arises from these discussions that needs reporting. **2011/12 &2012/13** Centres are asked to report harm/ errors and near misses in Induction and additional training has been provided Serious Incident reporting has increased in **2011/12** compared with previous year and an initial external benchmarks undertaken to define concerns or positive culture of reporting, with further benchmarks to be undertaken **2012/13 (Q4)**		**Amber**
(45)	Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery)	**2011/12** Quality Improvement Strategy is a 5 yr strategy for improvement with year on year objectives agreed with Centres and will form the baseline for their Centre objectives and process of review. **2012** The centres have produced their centre Quality development plans to support the overall strategy implementation. **2012** Centre performance meetings track progress on quality improvements and other key indicators **2012** The Centres have been asked to establish their governance arrangements with support from the COO and Q&S have tested out how mature these arrangements are in mid 2012 through the Committee. Variations in approach reflected size and stage of Centre development. **2012/13** Operational initiatives, i.e.: centres. Departments, link through to strategic objectives.		**Amber**
(46)	Internal communications (e.g. monthly news letter, intranet, notice boards) regularly feature articles on quality	The trust 'Quality News' a monthly update. This has been in place since April 2009. The newsletter can be found on the trusts website, so being used as a method of external and internal communication. 'Looking to the Future' newsletter, putting patients first, GP newsletter all provide updates and regular features on quality		**AMBER / GREEN**

	Structures & Processes

	Component	Commentary	RAG score	Composite score
(47)	**3a: Are there clear roles and accountabilities in relation to quality governance?** Each and every board member understand their ultimate accountability for quality	New CEO in **June 2010** and review of Quality Governance resulted in a new management structure with clinical leadership through clinical centres (devolution and cooperation document- **October 2010).** **2010/11** Revised sub Committee to reflect need for all Board members to have adequate information and assurance on quality and enable each Board member to understand their accountability for Quality. 2011 Board Development Programme paper went to the June Board- Sessions programme in until March **2013** . Chantry Vellacott being used to support some of the sessions. FT foundation project Board formed in **January 2012** to review all aspects of accountability. Quality Governance framework shared with Board in development session (**November '11)** as an initial outline with follow up in **February '12** alongside Quality Improvement (QIS) workshops **(December '11**)and development session on Quality objectives. **2011/12** Q&S workshop in February reviewed draft QIS and QGF and sought commentary and joint ownership of the accountability for Quality Commentary from original baseline to consider **2010/11** JD's for Board members that can be benchmarked to FT non execs and leading Quality Improvement examples for all Board members **2011/12** Appraisal for Board members with identification of any areas that need support re quality. **2012** revised committee structure to support level of Board members in seeking and gaining high level assurance with supporting Committee's carrying out the detailed reviews		AMBER/Green
(48)	There is a clear organisation structure that cascades responsibility for delivering quality performance from "Board to ward to Board" (and there are specified owners in-post and actively fulfilling their responsibilities)	**2010/11** Devolution and cooperation document established a process where a clear organisational structure commenced. **2010/11** Developed through the later part of 2010 and management of change to the operational mode in late 2011 to have Clinical centres with Centre Chiefs, centre clinical leads and a management structure that demonstrates clear accountability from ward to Board. **2011** TLT sessions held early in the stage of development demonstrates support and development for centre chiefs in their leadership role which included workshops on accountability agreement with corporate services and discussion on quality and their accountability. **2011/12** Clear JD's developed in the development of centres makes explicit the accountability for quality care and safety **2011/12 &2012/13** Ward to Board indicators proposal presented and approved to the Executive team and Q&S Committee, August 2011 and tested out in early Autumn 2011 and now fully in place in all centres during 2012 and reported at ward, centre and Board level. **2011/12 onwards-** Hospital Executive Committee provides the Centre Chiefs with a formal Sub Committee forum in which to formalise issues relating to Quality through papers on approach, papers for information and papers for approval. **2011/12** This committee is supported by Operational development Group which includes the senior managers /staff from each centre **2012** Centre performance meetings commenced in January'12 with focus on accountability for delivering quality improvements. Quality development plans identified in each centre to support structured process to implementing the Quality Improvement strategy. Centre Governance meetings are now well developed and tested out in **2012** to ensure robust process and follow up on specific Quality improvements including safety, patient experience and effectiveness.		Amber

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2012 revised committee structure to improve operational and clinical review at Centre and third tier committees to support Quality and Safety Committee to be able to gain assurance on trends and themes		
(49)	Quality is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions	**2010/11 &2012/13** Board agendas are organised under headings, one of which is: 'Quality and Safety'. Revised sub Committee structure (**Oct 2010**) was intro of a Quality and Safety Committee chaired by Non Exec Director. This feeds into the Board directly as with other formal sub Committee's to provide assurance. Integrated Performance report ensures quality core part of the Boards agenda		AMBER / GREEN
(50)	Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership	**2010/11 & 2011/12** Q&S Committee is a formal sub-committee of the Board. This committee has been in place since **November 2010**. **2011/12 onwards** The committee is chaired by a NED, with verbal and written highlight / variance report to the Board on key issues. Terms of reference reviewed at beg **of 2012** and then as part of all sub Board committee's in late **2012**. Quality and Safety Committee undertake self appraisal to review regular attendance and achievement of work programme **(May 2012)** Quality report and papers need to move towards higher level (trends and themes) seeking to provide assurance rather than detail- commencing with Integrated performance report mirroring PMR quality standards and variance reporting (**Dec '12 onwards**)		AMBER / GREEN
(51)	3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance? Boards are clear about the processes for escalating quality performance issues to the Board -Processes are documented -There are agreed rules determining which issues should be escalated	**2010 onwards** The Q&S Committee is a formal sub-committee of the Board with TOR making it clear about responsibility and escalation. **2010/11** onwards- The committee reports to the Board following each meeting. The report is a brief summary of the meeting. The NED Chair of the Q&S Committee presents this report and is available for any questions to be asked. Chairman of Q&S has considered this issue and revised the format of feedback to the Board **(2012).** Consideration of key focus for raising to the Boards attention and to enable challenge needs further consideration and was raised in Q&S workshop. Review in Board development **2011/12 & 2012/13** Performance paper to Public Board provides opportunity to raise and challenge clinical performance **2011/12 &2012/13** Areas of escalation can be evidenced through private Board papers which provide detailed discussion on wards of concern, high risk report, CQC report in detail and agreement that Q&S will review the actions and details. **2012/13** Board Performance report and late 2012- Integrated performance reports with clear triggers **2012** BAF- reviewed with revised reporting papers and committee structure to support. New or revised scores identified so the Board can note a deteriorating position or improved position..		AMBER
(52)	Robust action plans are put in place to address quality performance issues, With actions having: -Designated owners and time frames -Regular follow-ups at subsequent Board meetings	**2011** Review of Serious Incident reporting systems and processes with initial report from external review and action plan developed and tracked through by Q&S committee **2011, 2012** - High risk report to Q&S now enables a monthly review of SI management for Board challenge where required. The report also provides updates and actions taken following reporting. **2012** The Centre detailed review and tracking process for SI and quality issues are being monitored through Centres performance meetings through number of completed action plans **2011/12 &2012/13** Board demonstrate tracking of actions at the Board from Board discussions and brought forward to follow up **2011/12 &2012/13** Some actions designated to formal sub Committee's to follow through on the detail for		Amber

Enclosure 9

	Component	Commentary	RAG score	Composite score
		improvement (ward 15, Inpatient surveys etc) **2011/12 &2012/13** Performance report and recent Integrated performance report allows high level discussion on clinical performance, detailed review in Q&S through Quality report and action plan for improvement at Commissioning quality review meetings.		
(53)	Learning from quality performance issues are well documented and shared across the Trust on a regular, timely basis, leading to a rapid implementation at scale of good-practice	**2011** onwards CEO presentation in staff briefings, to the Board and in public meetings. **2010, 2011 and 2012** Quality account process and publication shared the improvement aims of LIPS and other priorities & will provide feedback on that process **2010/11** onwards Quality new shared good practice – ie Infection Control and prevention, LIPS, protected meal times, VTE **2012/13** Ward to Board quality performance shared with ward managers by senior nurses with action plans for improvement rolled out and reviewed through Quality improvement. NMF uses quality reports to review and encourage improvements **2012** Formal Improvements meetings held with clinical teams by Deputy Chief Nurse or Chief Nurse to ensure reduction in pressure ulcers from discussion about actions for improvement- shared within centres through lead nurses/ matrons- RCA and action plans **2012/13** Centre Governance meetings are able to demonstrate well documented improvements where applicable and the evidence for this along with key leads. **2011** Ward reviews- ward 22 and MAU being an example of where an external review and sharing of that process and outcomes has been shared with the team and led to improvements. **2012** Quality Improvement framework introduced for ward improvements leading to Matron, ward manager and Centre lead clinicians working towards improvements (ward 15 & ward 7, ward 28) **2011 & 2012** Bed bundle improvements and sharing of aims leading to initial improvements that are now being followed up **2011** LIPS – protected meal times piloted and rolled out across the Trust is an example of rapid improvement roll out.		**Amber**
(54)	There is well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns -Continuous rolling programme that measures and improves quality -Action plans completed from audit -Re-audits undertaken to assess improvement	Clinical Audit team in place at the Trust with annual programme of clinical audit and quarterly reports to Q&S committee **2011/12 &2012/13**. **2012/13** Q&S have revised TOR to support increased focus on clinical audit programmes and outcomes as well as wider clinical effectiveness and clinical outcome processes. **2010, 2011 and 2012** Quality account provides evidence of meeting the mandatory statement required each year and audit activity. **2011/12 &2012/13** Clinical audit Committee chaired by Associate medical Director which meets Quarterly and oversees the development and implementation of the clinical audit forward plan. **2011/12 &2012/13** Clinical audit forward plan reviewed by Audit Committee and linked to issues in the BAF, risk registers, incident reports, re audits and national and local priorities **2012/13** Internal Audit function in place with an annual work programme which includes a range of quality governance issues eg Quality Governance framework process from baseline model approved by the Board in March 2012 (Quality and Safety Committee reviewed Internal audit report in Dec '12)		**AMBER/ Green**
(55)	A whistleblower/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle	**2011/12** Whistle blowing Strategy/ Policy in place (Intranet) Training and support for staff on how to deal with this/ and support for a member of staff who does blow the whistle Notice in October 2011 payslips on the Whistle blowing Policy.		**AMBER**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		The means of collating how many referrals are made each year and the outcomes requires further clarity to make an effective assessment.		
(56)	There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels	**2011/12** Policy refinement to support recognition of best practice but performance management for addressing under performance needs to have an explicit policy framework –revised in March '12. **2010/11 &2012/13** Chairman's award at Board meetings supports recognition and incentivising good performance for Individuals and teams. **2010/11** LiA process a means for engaging staff to take forward projects and incentivise good performance and approach. **2010/11 &2011/12** Devolution and cooperation principles support recognition of good performance through accountability arrangements between CEO/ Operational Director to enable self governance but equally restricted/ special measures for those centres who are under performing. **2012/13** Appraisal process for under and achievement of objectives at all levels and performance management policies in place. **2011/12 &2012/13** Quality Improvement Strategy in place approved by the Board in March 2012 with each Centre producing a Quality development Plan in 2012 to support the implementation of the Strategy as well as local centre clinical priorities where agreed. **2012/13** Centre performance meetings focus on the performance of quality indicators, finance and wider activity performance. 2012/13 ward to Board measures being provided at ward, centre and Board level to monitor performance management of clinical Indicators as well as patient experience. **2012/13** NPQ being used as an indicator of patient experience with month on month improvement.		**Amber**
(57)	**3c: Does the Board actively engage patients, staff and other key stakeholders on quality?** Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance	**2010/11** Public consultation on "Keeping it in the County" sharing the concerns/ sustainability of services in the County and the options for improving quality. **2010/11** "Putting Patients first" Strategy approved at March '11 Board demonstrates focus on patients and quality improvements with Board performance reports monthly focusing on the headlines used in this Strategy. **2011/12** Patient stories to the private Board and Q&S Committee and HEC PEIP formed in **2011** with clear TOR to identify how they will as a wider patient and carer group will review quality outcomes and influence improvements through an active work programme. **2011/12** Quality reports shared at each Committee and Inpatient and Outpatient reports and action plans shared for open discussion on improvements required. **2011/12** PEIP training programme and accountability framework agreed in preparation for commencing work programme. **2012/13** PEIP work programme commenced with involvement in gathering patient stories, diaries, undertaking observations of care and working with commissioners and Educational reps on wards under a quality improvement framework. **2011/12 &2012/13** Quality reports shared in private and public Board but all quality reports shared with PEIP which includes statutory membership and voluntary membership. Annual Inpatient Survey results to the June 2011 Board and January 2012 OPD survey shared at Board Jan '12. **2011/12 &2012/13** CQR Monthly meetings held between the trust and the PCTs (ref to Q&S minutes from Jan 2011) **2011/12** Involvement of external stakeholders as well as internal Patient Experience Involvement		**Amber/Green**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		Panel(PEIP) groups and staff in the Quality Improvement Strategy which will provide a 5 year framework for Quality Improvement and will enable patients and pt reps/ stakeholders to hold us to account for the delivery of quality improvement outcomes. **2011/12 &2012/13** This links in with the publication of the Quality account where the performance negative or positive will be shared. Quality account process for publication of **10/11 & 11/12** report evidences the sharing of clinical outcomes whether poor or positive and involvement of formal patient representative groups, HOSCs/ CHC and PEIP in the process of agreeing the priorities, receiving the feedback on performance. **2011/12** Soft and hard intelligence flow chart shared with commissioners and Education colleagues in early **2011** to identify best approach to sharing good and bad performance **2012/13** as well as involvement in detailed reviews following quality improvement frameworks		
(58)	The Board actively engages patients on quality. E.g. – Patient feedback is actively solicited, made easy to give and based on validated tools	**2011/12** Patient Experience and Involvement Panel (PEIP) formed in 2011 and has now expanded (2012) to be more representative of local population with representation from different user groups and advocates for specific patient groups. **2012/13** -Active engagement of patients, carers and formal patient representative groups with varying interests. Monthly meetings and training programme in preparation for work programme which they all want to actively engage in to improve quality. **2011/12** Quality Improvement Strategy workshops engaged patients and carers on the issue of care delivery now and what they needed to see in quality improvements. Their feedback then fed into subsequent workshops and the patient group has reviewed drafts of the Strategy in its development. **2011/12** Patient stories to the Board and Q&S Committee and Hospital Executive Committee (HEC). **2012**- PEIP group engaged with OPD improvement work **2010** onwards The Trust has a PALs office. Information is collated and reported to the Board via the patient services dept so that all patient experience is considered together. Reported via the monthly Quality report or patient experience report to Q&S and Quarterly to the Board. **2011/12 & 2012/13** Quality report and ward quality improvement reports shared with PEIP as part of regular provision of ward to Board measures. **2010** onwards 'Looking to the Future' newsletter- provided public facing information. Moving to Quality news Quality account development for **10/11** report and in 2012 for the **11/12** report have been shared with formal patient representative groups as well as PEIP, sharing the priorities for Quality improvement and seeking views as to whether they are the right priorities. Also reporting on progress made on last years priorities.		**AMBER / green**
(59)	Patient views are proactively sought during the design of new pathways and processes	**2010/11** Public consultation on reconfiguration of services. **2010/11 & 11/12** Specific clinical pathways under reconfiguration seeking patient and public views as well as GP's and commissioners (FCHS) **2011/12 &2012/13** Patients views included in cancer build and booking and scheduling work Patient Information panel formed in 2012 to utilise patient and carer reps to review patient information being developed. **2011/12 &2012/13** Formation of a Patient experience and involvement Panel (PEIP) to engage patients in new pathways and improving care delivery seeking views of patients in real time as well as Observing care, gathering patient stories and Diaries. **2011/12 &2012/13** Ward to Board clinical metrics includes real time patient feedback (RTPF) with PEIP programme expanding the volume of RTPF that can be gained. **2010/11** onwards Q&S committee members review a clinical area prior to each formal Committee which		**Amber/Green**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		includes seeking the views of patients **2010/11** onwards Cancer patients and families involved in new Cancer build and reconfiguration work. 2012/13 patient representatives involved in ward reviews undertaken through a quality improvement framework.		
(60)	All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board	**2011/12** onwards –Quality report includes profile of Complaints with patient stories shared at the Board, HEC and Quality and Safety Committee. The Trust has a PALs office. Information is collated and reported to the Board through pt experience report **(2011)** and then through Quality report in **2011/12** which includes PALs feedback. **2011/12** onwards Information shared with PEIP members since July 2011 and work programme for 2012/13 evidences direct involvement and ability to challenge **2011/12** onwards Board members involved in Patient safety walkabouts and also pre- Q&S visits to wards and Depts to talk to patients as part of the format. Patient experience reports from patient reps and senior nurses fed back to PEIP on OPD improvement work and the summary output from public / patient real time feedback on services		**Amber/ green**
(61)	The Board regularly reviews and interrogates complaints data	**2010/11, 2011/12 &2012/13** The Board Performance/ Quality report includes complaints data. **2011/12** Quality report to Quality and Safety Committee on a monthly basis includes complaints data and PALs data picking up trends and themes. **2011/12** onwards Weekly operational forum "High risk scrutiny" meeting reviews complaints, SI and safeguarding data to ensure triangulation against these and to pick up continuity and agreed actions for improvement. **2012/13** PEIP workshop reviewed approach and style of complaint responses with recommendations. **2011/12** onwards Quality reports to Board and Quality and Safety Committee (previously the patient experience report) provides Board identification of trends and themes and Public Board papers provide this evidence also		**AMBER / GREEN**
(62)	The Board uses a range of approaches to "bring patients into the Board Room" (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing)	**2011** onwards The Board receive a patient story at most private Board meetings, as do the Q&S Committee. **2011/12** onwards Statutory patient representatives attend the public Board. **2011/12** Statutory visit reports shared at PEIP **2011/12 &2012/13** Prior to all Q&S Committee meetings there is an ' Ward/ Patient Walkabout'. This is attended execs and NEDs and feedback from the walkabouts is reported to the Q&S Committee. At the **September 2011** Q&S Committee a briefing paper on the walkabouts was taken. This paper resulted in a patient safety walkabout process. Patient Experience element of the Quality Report to the Board (**May 2011, July 2011 public, June 2012).** **2011/12** onwards Ward to Board metrics includes real time patient feedback to inform Centres and Quality and Safety committee of the improvements required. Shared with Board in **2011/12** and then wards/ Centres and Board from **2012/13**. PEIP workplan for **2012/13** includes observations of care, gathering patient stories, diaries and audits on protected meal times as well as involvement in ward/ Dept reviews when concerns into care delivery including real time patient feedback. **2012/13** PEIP members involved in direct feedback for ward staff in workshop environment to support improvement in quality and patient experience.		**Amber / GREEN**
(63)	The Board actively engages staff on quality, e.g. Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms)e.g. monthly "temperature gauge" plus annual	**2011 &2012** A staff survey is completed annually and the results are presented to the Board. **2011/12** LIA – Listening into Action. There have been 6 sessions 'staff conversations' around this and projects now being taken forward to demonstrate action on feedback. **2011/12** Pulse check process undertaken to identify staff feedback using key questions **2011/12 & 2012/13** Quality Improvement workshops held during Nov '11, Dec'11 and January '12 to listen		**Amber /GREEN**

Enclosure 9

	Component	Commentary	RAG score	Composite score
	staff survey)	to staff commentary and thoughts on quality improvement. Feedback from each workshop taken onto the next workshop and used in the formation of the QIS strategy. **2012** discussion with senior nurses and AHP regarding approved QIS and need to develop centre Quality development plans and in 2012/13 quality performance reviewed in Centre performance meetings. **2012/13** Nursing and Midwifery forum reviews Centre performance on quality and safety and engages teams on improvement actions **2011/12 & 2012/13** As part of transitional move to Clinical Centres the senior staff have been involved in workshops about how centres and corporate teams could and should work- reviewing accountability frameworks **2011/12 &2012/13** LIPS programme involved staff in improvements required on Safety improvements and Board committed to ongoing programmes to maintain staff in the improvements required **2011/12 & 2012/13** CEO engagement events- briefing / monthly meetings with staff to listen to issues/ concerns but also update staff on Trust activity and key messages		
(64)	All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board	**2011/12 &2012/13** A staff survey is completed annually and the results are presented to the Board. **2011/12** Development of the LIA scheme (ref to (23) (63)) **2012/13** Health and Wellbeing- draft strategy **2011/12** A 'Staff Story' presentation to the May 2011 Q&S Committee by a matron from critical care.		**AMBER**
(65)	The Board actively engages all other key stakeholders on quality, e.g. Quality performance is clearly communicated to commissioners to enable them to make educated decisions	**2011/12 &2012/13** Commissioning Quality reviews held Monthly between the trust and the PCTs/ CCG's. **2011/12** onwards Quality report shared internally is now distributed to Commissioning meetings under confidential cover. **2011/12** Quality performance metrics of soft and hard intelligence methodology shared with Education colleagues in University and Commissioning. **2011/12 &2012/13** PEIP, Commissioning and Education stakeholders involved in quality improvement framework with clinical areas needing support with improvements. **2011/12 &2012/13** Agendas are produced for CQR and distributed in advance of the meeting along with minutes. (ref to Q&S minutes from Jan 2011 onwards and Commissioning quality review meetings)) **2011/12 &2012/13** HOSC and Statutory patient groups are actively engaged with the Quality account process each year on the quality improvement priorities along with formal updates on improvements made. **2011/12** engagement of all stakeholders in development of Quality Improvement Strategy		**AMBER / GREEN**
(66)	Feedback from PALS and LINKs is considered	**2011/12 &2012/13** The Trust has a PALs office. Information is collated and reported to the Board through the patient experience report and then more latterly through a Quality report to public Board (Quarterly). **2011/12** onwards Patient experience and Involvement Panel (PEIP) provides membership across PALs, LINKs and Community Health Council (Welsh patient representative group) and other local patient representative group. Active engagement in work programme looking at different methods for real time patient feedback is considered in PEIP and Quality and Safety Committee. **2011/12 and 2012/13** LINKs formal enter and view reports shared in PEIP and with Centres for focus on improvement where required and follow up on actions.		**Amber/ green**
(67)	For Care pathways involving GP and community Care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway	The public Consultation around reconfiguration from **2010/11** demonstrates full public as well as clinician involvement. **2010/11** FCHS meeting minutes focused on specific pathways demonstrates clinician and GP involvement as well as clinician led meetings where the outputs from operational pathway discussions were presented and signed off. **2011/12 &2012/13** Urgent care network minutes will provide evidence of specific pathway work and also quality improvements.		**Amber**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2012/13 Bronze and Silver command meetings have provided the urgent flow discussions with partners about quality improvements **2012/13** Executive meetings with Community Trust exec colleagues to review joint work opportunities QUIPP meetings with LHE **2010/11** & **2011/12** Task and Finish group looking at RTT, backlog with clinical pathways and clinical risks- joint work with GP's **2012/13** GP leads and commissioning colleagues involved in gaining assurance following quality improvement framework with clinical areas (pre agreed process for Unannounced visits)		
(68)	The Board is clear about Governors' involvement in governance –	**2011/12 &2012/13** Board development sessions have included the future role of Governors for an FT.		**Amber /RED**

	Measurement

	Component	Commentary	RAG score	Composite score
(69)	**4a: Is appropriate quality information being analysed and challenged?** The Board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include: Key relevant national priority indicators and regulatory requirements	**2011/12 &2012/13** Board performance papers to the Board have been reviewed and revised. Format presented now reflects the Performance management regime for Monitor and includes key national priority indicators and supported by quality metrics on clinical indicators and patient experience. **2011/12** onwards –Quality report to Quality and Safety Committee included Quality metrics after Executive approval in October 2011 (Test your care, provides pre agreed metrics as used in aprox 12 other large acute Trusts). This dashboard provides ward level, centre level and Board level data that are now used and displayed at each level. **2012/13** Quality and Safety Committee have reviewed the dashboard data through a workshop to drill down to wards contributing to areas identified in Board metrics less positive performance. Committee members able to drill down if required in Committee discussion. High level Indicators refined in **2012** in Board report (Integrated performance report) and Quality report for committee refined.		**Amber/ Green**
(70)	Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each)	**2011/12** The Quality Improvement Strategy provides a five year framework for quality improvement covering the 3 domains- safety, effectiveness and patient experience. **2012** The Clinical centres have produced quality development plans which underpin the implementation of the strategy and again use indicators across the 3 domains of quality.. **2011** onwards a range of metrics reviewing clinical Indicators and patient experience metrics used in the Quality report to Q&S committee and from 2012 to the Board. **2012/13** the Board have received the performance report with the range of PMR national Indicators as well as the metrics used from test your care. **2012/13** The safety thermometer and Net promoter question results are also shared in addition to the metrics **2011 & 2012** Quality Account process uses the 3 domains to review and agree priorities for the year, from the **2011/12** consultation process for the Quality Improvement strategy will align and influence the quality account as well as new priorities influencing the updated strategy.		**AMBER / GREEN**
(71)	Select 'advanced warning' indicators	**2011/12** onwards Ward to Board measures provide a regular selection of Indicators which provide an		**Amber**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		indication of care provision that could indicate advanced warning. **2011/12** onwards: The High Risk scrutiny meeting held weekly reviews new complaints, serious incidents and safeguarding referrals which triangulate clinical issues and form and early warning of clinical areas which are struggling. **2011/12** Soft and hard intelligence flow chart agreed with Educational colleagues in 2011 has supported informal and formal discussions on early warning indicators to support early intervention for improvements. **2012/13** soft and hard intelligence process utilised to trigger Quality improvement framework with stakeholder involvement with level of assurance agreed		
(72)	Adverse event reports	**2010** onwards Datix system in use at the trust. External review of serious incident reporting commissioned in early **2011** to review key issues of adverse event reporting and management. **2011/12** onwards Quality and safety Committee reviewed the report and recommendations and track performance through High risk report to Private Board- outlining serious incidents reported and number of cases open and closed following investigation **2012/13** Performance of Datix FU and actions reviewed corporately as part of Centre performance meetings **2 011/12** onwards All incident reports are uploaded to the NRLS each week which informs patient safety work		**AMBER Green**
(73)	Measures of instances of harm (e.g. Global Trigger Tool)	**2011/12** LIPS programme introduced the overall aim to reduce mortality by 20% by 2013 and advocated GTT as a means to measuring instances of harm. Repeat GTT review was undertaken in **2012** for 2nd cohort of LIPS programme. Mortality data presented at Board through quality report and Integrated performance report **2012**. **2011/12** Centre specific mortality meetings within Medicine using methodology to measure harm and linked into Regional mortality work developing care bundle approach to improving mortality. Associate Medical Director commencing Trust wide mortality committee to establish regular measures of instances of harm across the Trust.		**Amber**
(74)	Monitor's risk ratings (with risks to future scores highlighted)	**2011/12** The Trust approved the baseline governance framework in March 2012 and placed an internal audit review of the initial process to seek views for improvement. **Dec 2012** Internal audit report shared with Q&S committee along with updated framework. The Trust provided an initial score and will use the self assessment score from the Quality Governance Framework and review six monthly through Board updates. The Trust Board receive an overall risk rating score from the PMR report to provide the score from all facets of performace. **2011/12** Q&S committee have reviewed each stage of the framework being developed and included 2 Board development sessions to discuss the draft versions of the framework prior to Board baseline approval. **Dec 2012** Benchmarks used to compare December version so that any refinements can be made for a summary document whilst building the evidence files to support Monitor process		**Amber**
(75)	Where possible/appropriate, percentage compliance to agreed best-practice pathways	Need further clarity to populate evidence in this area Consideration of examples NCEPOD papers in HEC Clinical audit programme to evidence against best practice- would need to clarify against programme High Impact actions on falls, pressure ulcers, Infection rates could contribute towards this ie use of evidence/ best practice and improving performance against best practice monitored?? Board papers on external reviews and comparison with recommendations?? Centres specific examples- ie Women and children's centre- neonatal statistics, maternity standards ie outcomes (low caesarean rates etc) but ***this is outcomes base rather than % compliance***		**RED**

Enclosure 9

	Component	Commentary	RAG score	Composite score
		Need further guidance before next update		
(76)	Qualitative descriptions and commentary to back up quantitative information	Board Performance reports contain qualitative and quantative information as well as other reports and meetings evidenced here. Need to maintain balance of descriptions as move towards higher level trend and theme reporting.		**AMBER/ green**
(77)	The Board is able to justify the selected metrics as being: -Linked to Trust's overall strategy and priorities -Covering all of the Trust's major focus areas -The best available ones to use -Useful to review	The Trust has a Quality Improvement Strategy approved in March **2012** which provides an agreed position for justifying selected metrics, with centre quality development plans using selected metrics from the 3 areas of quality **2012** . **2012/13** Current justification is based on regional and national priorities and required local performance improvements demonstrated through Quality account and centre plans. Referencing of priorities in Board papers –Integrated performance report provides Monitors required quality standards as well as other areas of performance. This provides a high level overview with variance reporting where required. **2011/12 &2012/13** Quality and Safety Committee review a more detailed quality performance report which includes a wider range of selected metrics. **2012/13** Centre performance meetings use a range of agreed KPI's for clinical Indicators and including ward to Board measures, Net promoter question and safety thermometer.		**Amber/Green**
(78)	The Board dashboard is backed up by a 'pyramid' of more 'granular 'reports reviewed by sub-committees, divisional leads and individual service lines	**2011/12 &2012/13** Cross reference to 77 but overall- The performance report at the Board provides agreed metrics being reported and high level commentary, this is supported by detailed Quality reports reviewing metric specific issues with ward and Dept trends and themes and comparison to previous month and ytd data. **2011/12 &2012/13** Evidence of review at HEC, ODG and Q&S committee and F&P committee. **2012/13** Centre performance meetings commenced Jan 2012 and provide ongoing evidence of review of this data in addition to Centre Governance meetings and agenda's. Ward to Board measures used at ward level and Centre level in addition to over all Board reports using the full range of measures		**Amber/Green**
(79)	Quality information is analysed and challenged at the individual consultant level	**2011/12** HEC provides an ability for Centre Chiefs to be actively involved in analysing reports, Quality information and outcomes. **2011/12 &2012/13** Centre Chiefs continue to connect with HEC quality data and the use of quality data in their Centre governance meetings- the use of the "test your care" metrics, safety thermometer and NPQ. Need to look at communication link to other senior practitioners through ODG and other professional forums **2012** Centre clinical leads and Gov leads provide an opportunity to review Quality information and track required actions. **2012** Each centre have produced a quality development plan with specific quality objectives. **2012** This is followed up in Centre performance meetingsance **2013/14** Revalidation process will in the next year develop an individual basis for review of Quality information.		**Amber**
(80)	The Board dashboard is frequently reviewed and updated to maximise effectiveness of decisions: and in areas lacking useful metrics, the Board commits time and resources to developing new metrics	The Board Performance report has been reviewed from **March 2011** and reviewed regularly in Q&S and refined following comments. Board performance report reviewed in **2012** to be aligned with discussion for higher level metrics and variance reporting with more detail in formal sub Committees, leading to Integrated performance report **2011/12 &2012/13** Ward to Board reporting through dashboards in Quality reporting		**AMBER**
(81)	**4b: Is the Board assured of the robustness of the quality information?**	**2011/12 &2012/13** Information Governance annual self appraisal will provide an overview of how robust our procedures are against national requirements. This will be reported in Quality account and an IG report to Board on an annual basis.		**Amber /RED**

Enclosure 9

	Component	Commentary	RAG score	Composite score
	There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness	**2010, 2011 &2012** Quality account process provides a national template and criteria for required reporting which can be tested. **2011/12** A review of Data Quality by Internal Audit. **2011/12** Ward to Board measures agreed and regional IT system utilised **2012/13** NPQ and Safety thermometer uses central data input and validation		
(82)	Each centre/service has a well-documented, well-functioning process for clinical governance that assures the Board of the quality of its data	**2012/13** Following the introduction of the Centres (previously 3 divisions) the Centres report to the COO with clear accountability agreements. **2012/13** Centre performance meetings are held monthly to review Quality, finance and activity. **2011/12** Quality Improvement Strategy approved in March 2012 supported by Centre quality development plans. Plans to integrate these into annual business planning process. Hospital Executive Committee (HEC) using the ODG as a conduit to operationalise strategic decisions. Standing Board item under 'Outcome summaries from Committees for information' is a 'Decision and Action summary from the HEC'. **2012/13** Each Centre has been developing their own governance arrangements and corporately the Quality and Safety Committee have reviewed each of these arrangements to test them out after 6 months in place. Metrics reported used to be able to drill down from Board level data to Centres and wards.		**Amber**
(83)	Clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents)	**2011/12 &2012/13** The clinical audit forward plan is developed in line with the clinical audit policy which describes the process for including national audits and additional local audits.. **2011/12 &2012/13** Tracking process in place monitored by the Clinical audit Committee. **2012/13** Assurance through Quality and Safety Committee and Audit Committee **2012/13** Governance processes for how each centre is establishing their own audit programmes to support this will be key for changing status		**Amber**
(84)	Electronic systems are used where possible, generating reliable reports with minimal ongoing effort. Information can be traced to source and is signed-off by owners	**2010** onwards -4Risk is an electronic risk register system. **2011/12 &2012/13** Datix, used for incident reporting is an electronic system. **2011/12** Health Assure- for CQC compliance **2011/12** Test your care IT metrics system purchased which allows for direct upload and report generation as well as benchmarking. **2012** Safety Thermometer and NPQ utilise an IT based system which enables central reporting and publications enabling benchmarks. Need FD review of SIRO systems to support owners and sign off		**AMBER**
(85)	There is clear evidence of action to resolve audit concerns	**2011/12 &2012/13** Clinical Audit plan with recommendation tracking in place monitored by clinical audit committee and with quarterly reports to Q&S **2011/1272012/13** Internal Audit plan in place, with follow ups on Internal Audit recommendations take place to identify whether recommendations are being implemented. **2011/12 &2012/13** Internal Audit report to the Audit Committee on all their findings, plus if recommendations are not being implemented. **2012** Centres will need to develop their own clinical audit work plan that is MDT in nature and approach and fitting with service needs/ weaknesses to demonstrate where and when improvements made. Formal reporting of clinical audits requires further work **2012** Centres will need to develop a formal way of tracking clinical audit recommendations and actions **2012** Quality and Safety Committee assurance by receiving quarterly audit reports on point 85, 86 and 87and a revised TOR to reflect this requirement to demonstrate improvements on governance in this area		**AMBER**
(86)	- Action plans are completed from audit (and subject to regular follow-up reviews)	Tracking process in place through clinical audit committee		**AMBER**
(87)	-Re-audits are undertaken to assess	Re-audits are built into clinical audit forward plan in line with clinical audit policy.		**AMBER**

Enclosure 9

	Component	Commentary	RAG score	Composite score
	performance improvement	Tracking process in place		
(88)	There are no major concerns with coding accuracy performance	On an annual basis an external body carry out a review of clinical coding- Internal audit reviewed clinical coding in **2011/12**. **2011/12** Report shared with the Board and with Audit Committee. **2011/12** Mortality discussed at Board and Quality and Safety Committee and LIPS forum against coding influence.		Amber
(89)	**4c: Is quality information being used effectively?** Information in quality reports is displayed clearly and consistently	Board Performance report; which goes to the Board every month. This has been developed since the start of **2011**. Now developed into a higher level Integrated performance report with variance reports to support. **2010, 2011 &2012** Quality Accounts produced in line with national guidance. **2011/12** The Quality Improvement Strategy was approved in March 2012 with each of the Clinical centre producing a quality development plan to support the implementation of the Strategy **2012/13** . The ongoing process for quality improvements and revised priorities will be agreed through the Centre business planning process. **2012/13** Board performance report refined to fit in line with FT quality sign off each month (PMR). **2011/12 &2012/13** Quality and Safety Committee receive a quality report which contains information being pulled from Trust systems and data is consistent. **2012/13** The Centre level Governance meetings will pull from the same data and therefore will be consistent.		AMBER/Green
(90)	Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful)	**2011/12 &2012/13** The Board Performance report used the RAG rating. The RAG rating needs to be based on explicit triggers for RAG-Integrated performance report. **2011/12 &2012/13** The Risk Register and BAF also use RAG ratings. The definitions behind these are included in the Risk Management Strategy **2012/13** Quality Impact assessments on CIP's/ service improvement changes/ bed reconfiguration have been undertaken with RAG rating based on risk strategy/ metrics within the Trust ***External benchmarking process needs to increase/ improve***		Amber
(91)	Information being reviewed must be the most recent available, and recent enough to be relevant	**2011/12 &2012/13** Data presented to the Board in the Performance report is 1 month behind for all Trust data. **2012** SHMI data is only nationally produced and published quarterly. **2011/12 &2012/13** The Information used at HEC, ODG is timely being consistent with Board and formal sub Committee's as 1 month behind. Also consistent with PCT quality and performance reviews		AMBER / GREEN
(92)	'On demand' data is available for the highest priority metrics	We know that we need a final IT/information Strategy and the requests for data vary in response. Trust priority over next few months to achieve timely support and improved systems Further clarity on this section before update		RED
(93)	Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate)	**2012/13** Metrics used at Board is reviewed against the PMR/ Monitor reporting and humanised/ personalised reporting used where possible. Quality and Safety Committee will continually review and refine during 2013. **2011/12 &2012/13** Data on incidents is included as the absolute number, as are the number of complaints. **2011/12 &2012/13** Infection Control- Board presentations made and Q&S with personalised (but not regular-so need to consider) Quality reports to public and private Board utilise a range of mortality figures used nationally and regionally but also focus on the crude death rates.		AMBER
(94)	Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performances	**2011 &2012** GTT, Mortality reviews, LIPS programmes reviewing key safety themes has led to a reduction in Mortality figures (Crude mortality as well as HSMR). **2011 &2012** High Impact Intervention audits are shared across clinical centres and Hand hygiene is one example of where poor medical compliance was shared and has resulted in improvements.		AMBER/ Green

Enclosure 9

	Component	Commentary	RAG score	Composite score
		2010/11 Backlog and Pending reviewed by Board commissioned external review and enabled LHE and Trust improvement to 18 Weeks RTT. **2011/12 &2012/13** Patient falls – internal Falls task group and performance report: Quality: April 2011. **2011** MAU external report and action plan has led to improvements Ward level clinical Indicators "Test your care" used to review clinical standards and patient experience at ward, centre and Board level, which has led to improvements in focus on patient care, with quality rounds and checks being introduced and leading to improvements. **2011/12 &2012/13** Reviewing information on documentation has led to a year of review and evidence based changes to Nursing documentation supported by education colleagues, commissioners and CQC..		

Summary :

5 - the same
2 - better
3 - worse

2011

Appendix 2

Monitor Governance Quality Self-Assessment

Quality Governance Framework - Self Assessment : RAG Rated

Strategy	Capabilities and Culture	Processes and Structures	Measurement
1A Does Quality drive the Trust's Strategy? T - COMPLIANT M – Green –	2A Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the Quality Agenda? T - COMPLIANT M - Amber / Green ↓	3A Are there clear roles and accountabilities in relation to Quality Governance? T - COMPLIANT M - Blue → Green –	4A Is appropriate Quality information being analysed and challenged? T - COMPLIANT M - Green ↑
1B Is the Board sufficiently aware of potential risks to Quality? T - COMPLIANT M - Amber / Red ↓	2B Does the Board promote a Quality-focused culture throughout the Trust? T - COMPLIANT M - Green ↑	3B Are there clearly defined, well understood processes for escalating and resolving issues and managing Quality performance? T- COMPLIANT M - Green –	4B Is the Board assured of the robustness of the Quality information? T - COMPLIANT M - Amber / Green –
		3C Does the Board actively engage patients, staff and other key stakeholders on quality? T – COMPLIANT M – Amber / Green –	4C Is Quality information used effectively? T – COMPLIANT M – Amber / Green ↓

Rag Rating Criteria (based on CQC Framework)

Green	Fully Compliant
Yellow	Fully Compliant but minor development areas identified to sustain compliance
Amber	Partially Compliant
Red	Non-Compliant

Monitor RAG Rating

Green

Amber / Green

Amber / Red

Red

Blue – still gathering evidence