Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – June 2012

Agenda Item Number: 90/12
Enclosure Number: (3)

Subject:	**FT Quality Governance self assessment**
Prepared by: **Sponsored by:** **Presented by:**	Fiona McNeight, Head of Governance and Patient Safety Tracey Stenning, Governance Compliance Manager Julie Dawes, Director of Nursing Simon Holmes, Medical Director
Purpose of paper *Why is this paper going to the Trust Board?*	Discussion requested by Trust Board Regular Reporting
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	The updated action plan was presented at the FT Committee on 6th June 2012. The Committee agreed that discussion was required at Trust Board in respect of reducing the risk rating which currently stands at 5.5, based on progress with the action plan. Feedback from the SHA has suggested particular focus on elements 3c and 4a for potential reduction in score. The current risk score is on page 26.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	Whether the risk rating, currently at 5.5, can be reduced in light of progress against the action plan in any of the 10 elements.
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Updated action plan and risk rating to be submitted to the SHA with additional evidence requested.
Consideration of legal issues (including Equality Impact Assessment)?	Considered – None.
Consideration of Public and Patient Involvement and Communications Implications?	Considered – None.

Monitor's example of good practice	Position statement	Evidence
1. Strategy		
1a. Does quality drive the trust's strategy?		
Quality is embedded in the Trust's overall strategy.	• Five year Integrated Business Plan and Clinical Services Strategy currently under development – the quality content of this and its alignment with commissioners will complete assurance. • Trust Strategies ratified: - Quality Improvement Strategy - Risk Management Strategy • Trust Strategies to be confirmed as ratified: - Integrated Governance Strategy - Patient and Public Involvement Strategy TBC - Communication Strategy TBC	• Strategies and minutes of committee ratification • IBP • Strategic objectives. • Draft timetable of FT development plan and IBP.
- 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.	• The Trust quality priorities are identified from a number of routes and while several are identified nationally or regionally, the Trust also has processes in place to identify local priorities. These priorities are set out in the Trust's Quality Improvement Strategy and on an annual basis through the Quality Account. • The Trust Transformation Programme supports continuous quality improvement e.g. transforming patient pathways	• Quality Improvement Strategy • Quality Accounts • Transformation Programme
- Quality goals reflect local as well as national priorities, reflecting what is relevant to patients and staff. - Quality goals are selected to have the highest possible impact across the overall Trust.	• The three sub-groups of the Governance and Quality Committee (patient safety working group, patient experience steering group and clinical effectiveness steering group) support the identification of priorities and drive the respective agendas which underpin the Quality Improvement Strategy and Quality Accounts. There is NED representation on the PSWG. • Any issues identified by these groups feed into the Trust's Quality and Governance Committee which also has representation from the Trusts shadow governors and a NED. The terms of reference for this group clearly state that the purpose of the committee is to ensure that there is continuous and measurable improvement in the quality of the services provided, and the minutes reviewed support this. Issues from this group can in turn be raised at the Trust Board and identified as quality priorities. • The Trust has published Quality Accounts which reflect local e.g. discharge and national quality priorities. There is consultation with internal and external stakeholders (OSC, LiNKs, difficult to reach groups) to ensure priorities reflect patient and staff views.	• Quality Accounts • Consultation documentation • Contract negotiation consultation documentation • Commissioner meetings • Governance and Quality Committee minutes and ToR • PSWG, CESG and PESG minutes and ToR • Quality contract

Monitor's example of good practice	Position statement	Evidence
	• The Trust engages with Commissioners and appropriate clinical and non-clinical staff to ensure the Quality Contract and CQUIN indicators also reflect local and national quality improvement priorities and align with the Quality Account.	
- Wherever possible, quality goals are specific, measurable and time-bound.	• The 2011/2012 Quality Account and Quality Contract will include specific, measurable and time bound metrics. • The Patient Safety Action Plan provides specific and measurable actions with identified leads.	• Quality Account • Quality contract • Patient Safety Action Plan
- Overall Trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service).	• Each Clinical Service Centre (CSC) has a Governance Committee which integrates local consideration of business and quality issues. These committees report to the Risk Assurance Committee (RAC) and the Governance and Quality Committee. The Governance and Quality Committee is a sub-committee of the Board and minutes are presented monthly to the Board. • Each CSC will be required, from 2012/2013, to produce a CSC specific Quality Improvement Plan inclusive of the priorities within the Trust Quality Improvement Strategy, Quality Account and local issues (arising from complaints, SIRI's etc). • Implementing a CSC performance assurance framework which assesses against both Trust-wide quality metrics and specific quality metrics identified by each CSC as key performance indicators relevant to their services.	• CSC integrated performance reports • CSC quality improvement plan (from 2012/13) • CSC Governance Committee minutes, reports and ToR
- There is a clear action plan for achieving the quality goals, with designated lead and timeframes.	• Ensure IBP and CSC quality improvement plan contains clear plans for achieving quality goals, with designated lead and timeframes when developed. • The Quality Improvement Strategy contains clear issues, actions, responsible leads and deadlines.	• IBP • Quality Improvement Strategy • CSC quality improvement plan (from 2012/13)
Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the Trust and the community it serves.	• Publication of Quality Accounts on the Internet and through NHS Choices, following consultation and feedback from stakeholders (internal and external). This process is being strengthened for the 2011/2012 Account to include difficult to reach groups. • Monthly and quarterly Board reports provide updates against quality priorities. These are available on both the Internet and Intranet. • Quality Improvements noted in the Trust monthly Team Brief and weekly Chief Executive Message. • The Trust clinical quality review meetings evidence clear communication on quality with commissioners.	• Trust values • Team brief examples • CEO weekly message and Team Brief examples • Quality Account consultation documentation • Board reports • CQRM minutes • Pulse survey results • Quality Improvement

Monitor's example of good practice	Position statement	Evidence
	• The 2010 CQC staff survey results identified room for improvement in internal communication, as the Trust is in the lowest 20% for overall staff engagement. This is an area the Trust are putting significant effort into improving, and are working with the SHA and Aston University to concentrate on improvements in role clarity and objective definition. The Trust must ensure that improvement can be evidenced prior to application. • The draft quality improvement strategy clearly articulates the organisation's quality priorities, and the leads in each area. Evidence of the Trust communicating and presenting these quality priorities, and progress on specific goals would also strengthen evidence in this area once the strategy is ratified. • The Maternity Strategy (Nurture Programme) has priorities linked to National Policy, Commissioning specification and current evidence (e.g. NICE guidance). • Quality priorities were presented at a business planning support workshop in December 2011 based on priorities outlined in the 2012/13 Operating Framework, CQC priorities and local priorities. • Both the Governance and Patient Safety Intranet page and the Quality Webpage on the Trust Internet need to be further developed to communicate quality goals clearly. • The Trust vision and values have been widely communicated through various methods	Strategy • Maternity Strategy • Examples of communication on specific quality goals to ensure a clear process from identification to prioritisation, through planning and tracking to communication on outcomes. • Business planning support workshop presentation • Trust values communications
The Board regularly tracks performance relative to quality goals.	• Monthly and quarterly Board reports clearly identify quality priorities and provide updates on progress and/or identifies emerging issues and actions to address. • Quality and performance 'heatmaps' contained within each monthly Board reports to track ongoing performance. • Performance is also tracked through CSC Executive performance reviews which will utilize the CSC performance assurance framework. • Clinical dashboard implemented providing ward to board transparency of quality. • There are Executive and Non-Executive walkarounds ('Captains' Rounds and Safety Walkabouts), where staff are able to raise concerns directly. • Patient Safety Walkarounds are non-executive director led and focus on issues affecting patient care. The action logs demonstrate identification of issues to directly improve patient safety and experience. Outcomes from the	• Monthly and quarterly Board reports • Screenshots of Clinical Dashboard • Safety walkabouts • Trust workshop minutes • Safety Walkabout reports to the Board

Monitor's example of good practice	Position statement	Evidence
	safety walkabouts will be reported at the Board by the Non-executive directors from February 2012.	

SHA comments:

- The process described by which issues identified by the three sub-groups of the Governance and Quality Committee are fed up to the Board is clear and robust. We would like to better understand how these groups are informed about issues from staff to feed them up i.e. how the Trust engages with "appropriate clinical and non-clinical staff", perhaps giving an example.
- As the assessment points out, "communicating and presenting these quality priorities, and progress on specific goals would also strengthen evidence in this area once the strategy is ratified". We also suggest consideration is given to seeking assurance that these communications goals are well understood. Monitor will ask staff at a range of levels questions about the organisations priorities and how there areas compare to others and the Trust should assure itself regarding this.
- We would like to see some up to date examples of the briefings and CEO message to assure ourselves of the linkages that are being made.

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.	• The Board Assurance Framework (BAF) is submitted monthly to the Board and the Audit Committee. • The Board receives regular information on potential risks, evidenced in the Board Assurance Framework, Risk Register, Board Quality Pack and Board quality reports. These sources clearly outline the depth of information made available to the board. The assurance framework clearly shows the importance the Trust places on ensuring the delivery of positive patient outcomes as evidenced by the importance placed on HCAI performance and performance against overall quality standards • Members of the Board are actively updated with information on clinical audit findings as illustrated in Audit Committee meeting minutes where clinical audit activity and how it relates to the overall risk management audit is discussed. This is a good indicator that board members assess and understand current and future risk to quality and ensure that these are not overlooked and measures are instigated to mitigate them. • On a monthly basis the Board is informed of risks associated with poor performance against a number of measures through the performance and quality Board reports. • Sustainability workstream risks are monitored at the Turnaround Committee. • Fortnightly patient safety walkabouts led by the Non-Executive Directors which facilitates triangulation of information received by the Board.	• BAF and Board/Audit Committee minutes • Risk Register and Board minutes • CSC risk register examples • Monthly and quarterly Board reports • Turnaround Committee minutes • Monthly CSC and corporate workstream reports • Patient safety walkabout action logs • Audit Committee CQC reports • Board compliance reports • Governance and Quality Committee minutes • SIRG minutes • Risk Management newsletter

Monitor's example of good practice	Position statement	Evidence
	• Monthly Executive 'Captains Rounds'. • Care Quality Commission (CQC) updates against the essential standards provided at each Audit Committee meeting (commenced May 2011). Compliance updates and Quality and Risk Profile (QRP) monitoring provided in the Quarterly Compliance reports to the Board. • The Trust has an electronic safety alert system for the dissemination of safety alert notices and other publications from the NPSA. The status of alerts is included in the quarterly Quality Board report and monitored at the Governance and Quality Committee. • All Serious Incidents are reviewed, actions monitored and learning shared, through the Serious Incident Review Group (SIRG). This group is chaired by either the Director of Nursing or Medical Director. • Risk Management newsletter highlights lessons learnt.	• Monthly Integrated performance report. • Monthly Quality exception reports.
The Board regularly reviews quality risks in an up-to-date risk register.	• The 'red' risks contained within the Trust-wide risk register are presented to the Board monthly, with the full risk register being reported quarterly. • The Audit Committee discuss the Assurance Framework at each meeting and raise any concerns over management of risk.	• Board minutes • SMT minutes • Audit Committee minutes
The Board risk register is supported and fed by quality issues captured in directorate/service risk registers.	• Each CSC has a risk register which is monitored by the CSC Governance Committee. CSC risks are escalated to the Trust-wide risk register following discussion and agreement at the RAC. • The RAC reviews the full Assurance Framework and Trust-wide risk register on a monthly basis. • RAC minutes distributed to the Board.	• Sample of CSC risk registers and CSC Governance Committee minutes • RAC minutes • Board minutes
The risk register covers potential future external risks to quality (e.g. new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks.	• The Assurance Framework and Trust-wide risk register covers elements of potential external risks, however, this needs to be further developed.	
There is clear evidence of action to mitigate risks to quality.	• Serious risks from CSC risk registers are included in the Trust-wide risk register or Assurance Framework. • Serious risks from the sustainability workstreams are escalated to the RAC and are included on the Trust-wide risk register or Assurance Framework as appropriate.	• BAF and risk register • Audit Committee minutes • RAC minutes and ToR • Sustainability risk registers • Sustainability/Turnaround

Monitor's example of good practice	Position statement	Evidence

	• The impact of financial and operational initiatives is monitored on an ongoing basis as risk leads are associated with each sustainability work stream, each work stream has a risk register identifying impact of initiatives on quality. Risks presented to the Sustainability/Turnaround Committee
	• Actions to mitigate risks to quality are monitored through the RAC and Audit Committee.
	• All Serious Incidents are reviewed, actions monitored and learning shared, through the Serious Incident Review Group (SIRG). This group is chaired by either the Director of Nursing or Medical Director.
	• The Patient Safety Working group monitors safety metrics on a quarterly basis and a Patient Safety report is provided to the Board quarterly.
	• The Clinical Effectiveness Steering Group monitors Dr Foster data on a monthly basis and reports to the Board quarterly.
	• Action plans associated with CQC inspections
	• Specific examples of how action has been taken to mitigate risk to quality
	  • Winter plan / winter ward
	  • Business continuity for the day of the Strike (30th November 2011)
	  • Emergency Department queue control.
	  • Carillion sewage problems.
	  • Safeguarding policy
	• Specific examples of a clear process that ensures learning is systematically identified and shared; and examples that show this is effective include.
	  • 48 hour SIRI review panels
	  • 'Never event' related to retained laparoscope part
	  • Serious Case Review – Paeds.
		Committee minutes
		• PSWG minutes
		• CESG minutes
		• CQC action plans
		• SIRG minutes
		• Dr Foster reports
		• SIRI panel outcomes
		• Never Event action plan

Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment).	• The Medical Director and Director of Nursing will sign off all CIP and business plans • Risk assessments and monitoring measures to be implemented for all CIP plans prior to sign off. • Risk lead identified for each sustainability workstream. • Each workstream has a risk register and red rated risks which are transferred to the Trust risk register are presented at each Turnaround Committee. • Workforce reduction risk assessment template introduced to assess the risk of non replacement of any post.	• Risk assessments • Turnaround minutes / CIP plans • Risk forms for redundancy

Monitor's example of good practice	Position statement	Evidence
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).	• Commencement of transformation programme to review the end to end pathways for elective and unscheduled care using pathway mapping to identify problems and waste in the pathway, a future state map will be drawn up and agreed with a plan developed to deliver the change	• Future state map once developed
- Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality).	• McKinsey Healthcare Institute benchmarking is being used to identify Trust performance for 81 metrics across an agreed peer comparator set to identify improvement opportunities and areas of good practice. • Better care better value metrics being used to identify performance opportunities • Institute for Innovation and Improvement published evidence based QIPP publications being reviewed to identify quality and financial improvement opportunities • Dr Foster analysis conducted on length of stay down to specialty and consultant level to reduce variation in patient length of stay where length of stay is greater than peers. • Dr Foster and Institute for Innovation and Improvement benchmarked information used to inform the out patient improvement work reducing DNA's, reducing under utilisation of clinic slots.	• Presentations to EMT, SMT and General Managers (GMs) • Minutes of Turnaround Committee and workstream reports and plans • Diagnostics completed for OP and LOS improvement work provided to GM's for implementation
- 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).	• Monitoring of the quality of end of life care since the closure of G5 has demonstrated that quality has not been negatively impacted	• Bereavement survey results. • End of life audit results
The Board is assured that initiatives have been assessed for quality.	• Risk lead identified for each sustainability workstream. • Each workstream has a risk register and red rated risks which are transferred to the Trust risk register are presented at each Turnaround Committee. • Workforce reduction risk assessment template introduced to assess the risk of non replacement of any post.	• Risk assessments • Turnaround minutes / CIP plans • Risk forms for redundancy
All initiatives are accepted and understood by clinicians.	• The sub-Board meeting Senior management Team (SMT) oversees the operational delivery of quality improvement initiatives. All Chief of Service	• Turnaround Committee minutes and ToR

Monitor's example of good practice	Position statement	Evidence
	attend this meeting for clinician engagement. • The Turnaround Committee provide challenge around the delivery and risk mitigation for CIP plans. Membership includes the Medical Director and Director of Nursing. • Each CSC has a medical and nursing governance lead and governance committee where the CSC risk register (formulated by the specialty risk registers) is discussed, with any key risks identified for escalation to the Risk Assurance Committee	• SMT minutes and ToR • CSC Governance Committee minutes • RAC minutes
There is clear subsequent ownership (e.g. relevant clinical director).	• Each CSC has a medical and nursing governance lead and governance committee where the CSC risk register (formulated by the specialty risk registers) is discussed, with any key risks identified for escalation to the Risk Assurance Committee • The sub-Board meeting Senior management Team (SMT) oversees the operational delivery of quality improvement initiatives. All Chief of Service attend this meeting for clinician engagement.	• SMT minutes
There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistleblower policy.	• The Trust has a formal process through the Whistleblowing policy available on both the Internet and intranet. • Informal processes include: - The Chief Executive Officer holds regular forums where any member of staff can attend to discuss any concerns. - The Director of Nursing holds regular forums where any member of nursing staff can attend to discuss any concerns. - Staff raise concerns directly with the Executive team, e.g. the Director of Nursing. - There are Executive and Non-Executive walkarounds ('Captains' Rounds and Safety Walkabouts), where staff are able to raise concerns directly. - The Joint Council Negotiating Committee are able to raise concerns on behalf of staff. - Feedback is received from Trainee's (i.e. Doctors) and fed back to the Board accordingly.	• Whistleblowing policy • CEO forum invites • Board minutes
Initiatives' impact on quality is monitored on an ongoing basis (post-implementation).	• Every month the CSCs and corporate workstreams produce a report where the risks are reviewed and RAG rated, submitted to turnaround	• CSC and corporate workstream reports • Turnaround Committee minutes

Monitor's example of good practice	Position statement	Evidence
Key measures of quality and early warning indicators identified for each initiative. Quality measures monitored before and after implementation. Mitigating action taken where necessary.	• Each turnaround workstream has an identified baseline and measures are tracked during implementation. Risk assessments are undertaken for each workstream and identified risks are monitored through the Turnaround Committee. This process has been reviewed and will be further developed. The Medical Director and Director of Nursing will now sign off all CIP plans and business plans and review the impact on quality and ensure quality measures are identified. These quality measures will be tracked during and post implementation and mitigating actions taken as required.	• Workstream quality risk assessments and measures (once implemented)

SHA comments:

- The horizon scanning and PEST analysis that forms part of the IBP development may give another source of potential external risks.
- The SHA normally recommends all risks at this level are in the corporate risk register, with some on also on the BAF. It would be useful to have a clear understanding of the approach you describe with sight of a policy/strategy where this is described.
- It is assuring that there is a formal process to risk assess all CIPs, and that the Medical Director and Director of Nursing will sign off all CIP and business plans. We would very much like to see a log and / or process for this to see how the process affects monitoring / adjustment of plans and to see if plans are ever rejected in this process.
- We have reviewed your patient safety walkabout action log in the past but as that was over 12 months ago, would be keen to see an updated version.
- We would also be keen to see a recent example of the Risk Management newsletter, and content from your Safety Day showing how learning is shared.

2. Capabilities and culture		
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).	• Board minutes provide evidence of rigorous challenge of quality performance. • Audit Committee minutes provide evidence of challenge of quality performance. • Challenge of the Performance and Quality Heatmaps at the Board, evidence in minutes. • Challenge of CSC performance at the monthly performance reviews. Resulting CSC action points. • Non-Executive director and Governor membership at Governance and Quality Committee. • Audit Committee chaired by Non-Executive Director.	• Board minutes • Audit Committee minutes • G&Q Committee Terms of Reference • Audit Committee Terms of Reference • Action points arising from CSC performance reviews

Monitor's example of good practice	Position statement	Evidence
The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board.	• Recent appointment of new Non-Executive and Executive Directors. One NED is a retired respiratory Consultant and therefore provides the necessary clinical challenge. • Monthly Board workshops. • Quality Governance presentation and discussion at Board workshop. • Planned Board development programme demonstrating clinical, quality and patient focused content currently being developed.	• Board workshop schedule • Quality Governance Board presentation and minutes • Board structure • Planned Board development programme (once developed)
Board members are able to:	• These will be tested at Board-to-Board with SHA.	
- Describe the Trust's top three quality-related priorities.	• These will be tested at Board-to-Board with SHA.	
- Identify well- and poor-performing services in relation to quality, and actions the Trust is taking to address them,	• These will be tested at Board-to-Board with SHA.	
- Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures).	• These will be tested at Board-to-Board with SHA.	
- Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them.	• These will be tested at Board-to-Board with SHA.	
- Be clear about basic processes and structures of quality governance.	• These will be tested at Board-to-Board with SHA.	
- Feel they have the information and confidence to challenge data.	• These will be tested at Board-to-Board with SHA.	
- 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.	• These will be tested at Board-to-Board with SHA.	
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	• The Board were made aware of significant sewage leaks within the Paediatric Department. Both the Executive and Non-Executive Directors have been actively involved in resolving this issue.	

Monitor's example of good practice	Position statement	Evidence
of the Board's role in leading on quality).		
The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained.	• The Board has undertaken a self assessment using external IT software both individually and collectively. • Other Board development has been limited but a development programme for 2012/13 is currently being developed.	• Assessment report
Board members have attended training sessions covering the core elements of quality governance and continuous improvement.	• Quality Governance presentation and discussion at Board workshop. • The Trust has an on-going Board development programme via monthly workshops focusing on strategy, vision, and values. Previous examples have included a session on CQC assessment with input from the CQC, and sessions on Patient Safety. NEDs have also attended externally ran Patient Safety workshops. • Board member attendance at SHA meetings.	• Quality Governance Board presentation and minutes • Board workshop minutes
SHA comments: • While there is only a brief mention of Board self assessment, we understand some has taken place and more work, including some external assurance, will be taking place over the coming months. • We would also like to see the Board development programme which is currently work in progress. • The Executive and Non Executive involvement in key quality commitments is good. Board minutes reviewed showed clear examples of challenge resulting in action. Board observations or other external views would be good evidence in this area. • You are right to indicate that many of these areas will be tested by SHA Board to Board – you may wish to consider seminars or mock Board meetings in preparation.		
2b. Does the Board promote a quality-focused culture throughout the organisation?		
The Board takes an active leadership role on quality.	• Quality Accounts 'signed off' by the Board prior to publication. • The Trust board have a number of process in place to promote a quality focused culture including: - 'Captains Rounds' which are executive led and detailed look at a range of issues from cleanliness and health and safety, to giving external scrutiny relating to the environment. - Patient Safety Walkarounds are non-executive director led and focus on issues affecting patient care. The action logs demonstrate identification of issues to directly improve patient safety and experience. Non-executive directors will speak to executives if assurance is required after visits. • The Trust has established a core set of values, created by staff and endorsed by the Board. Values posters are in all clinical and non-clinical	• Quality Account and Board minutes demonstrating 'sign-off' • Patient safety walkabout Programme and action logs • Trust values and minutes where endorsed by the Board • Monthly and quarterly Board reports

Monitor's example of good practice	Position statement	Evidence
	areas. The values are based on improving quality. • The Trust regularly reviews, through quarterly and monthly Board reports, the results of patient and staff feedback and has a real-time patient feedback system (Optimum). Patient stories have been presented to the Board. The Director of Nursing personally reviews all complaints.	
The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations).	• Analysis has been conducted against the recommendations of external reviews e.g. Mid Staffs, Francis enquiry, with action plans implemented.	• External review action plans • Board minutes
The Board regularly commits resources (time and money) to delivering quality initiatives.	• Business cases are approved through Trust Planning Committee which support quality improvement. The Committee is chaired by the Director of Finance. • NED and Executive membership of Governance and Quality Committee and Patient Safety Working Group. • NED chairs Stroke and Transplantation Committees. • Trust Board support for QUIPP e.g. Productive series	• Governance and Quality Committee ToR. • Patient Safety Working Group ToR. • TPC ToR and minutes • Stroke Committee ToR and minutes • Transplantation Committee ToR and minutes • Productive ward and theatres reporting within Quality Board Reports
The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members).	• A NED chairs the Transplant Committee. • NED membership of Governance and Quality Committee and Patient Safety Working Group. • NED membership of theThrombosis Committee.	• Governance and Quality Committee ToR. • Patient Safety Working Group ToR.
The Board encourages staff empowerment on quality.	• Pilot of MaPSaF (safety culture questionnaire) completed in MSK, requires further roll-out. • The Trust has an organisational vision, and a core set of values created by staff and endorsed by the Board.	• MaPSaF pilot results • Trust values
Staff are encouraged to participate in quality / continuous improvement training and development.	• Various courses undertaken (e.g. LIPS, Advanced Improvement Skills in Quality and Safety, preceptorship safety training). • Aston leadership programme currently ongoing within the Trust.	• Aston Leadership programme
Staff feel comfortable reporting harm and errors (these are seen as the basis for	• The Trust are high reporters of SIRIs in NHS South Central, showing a positive attitude to reporting and learning.	• NPSA reports • PSWG minutes

Monitor's example of good practice	Position statement	Evidence
learning, rather than punishment).	• Safety metrics presented quarterly at the patient safety working group demonstrate an increase in reporting. • Training on risk management and incident reporting (included in corporate and junior doctor induction) emphasises learning from incidents and the Being Open policy. • The MaPSaF has been piloted in MSK and there are plans to further roll this out during 2012/13 to assess the safety culture of the organisation following a presentation at the PSWG. • Use of the Global Trigger Tool. Since July 2010 the Trust has seen a decrease in the number of harm events. The majority of events are not related to serious harm and since July 2011 there have only been 2 low severity harm events identified.	• Risk management training material • MaPSaF pilot results • Global Trigger Tool reports.
Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery).	• Identified lead for each priority • Quality contract compliance monitored through the G&Q Committee and leads held to account for delivery of indicators	• G&Q Committee minutes
Internal communications (e.g. monthly news letter, intranet, notice boards) regularly feature articles on quality.	• Quality Improvements noted in the Trust monthly Team Brief, LINK and weekly Chief Executive Message. • Risk Management newsletter highlights lessons learnt.	• Team Brief • CEO weekly message • LINK • Risk Management newsletter

SHA comments:

- Board membership on key committees is described, and the captain's rounds and safety walkarounds ensure there is visible demonstrable leadership. NED chairs of both the transplant and thrombosis committees are good additional assurance and any other examples of specific NED leadership on quality improvement should be added.
- The statement "Patient stories have been presented to the Board" makes this sound like an occasional or one of practice, rather than routine. Some organisations start every Board meeting with walkaround feedback, or include specific stories of complaints, SIRI, or improvements at every meeting to add the patient perspective to the themes and trends presented.
- Examples that show how "Staff are entrusted with delivering the quality improvement initiatives they have identified" would strengthen the staff empowerment element. The training described is good – however examples of how this is used would be better.
- The high reporting rates are positive particularly when viewed alongside use of other measures showing a fall in actual harm. What do staff survey results say about reporting processes and rates? If staff were asked about reporting rates – would they know PHT were a high reporter and that this is positive?

Monitor's example of good practice	Position statement	Evidence
3. Structures and processes		
3a. Are there clear roles and accountabilities in relation to quality governance?		
Each and every board member understand their ultimate accountability for quality.	• Job descriptions (e.g. Director of Nursing and Medical Director) outlines clear accountability for quality. • Board observations will provide additional assurance regarding this. • New Board Executive responsibilities have been agreed (January 2012) and distributed to Chiefs of Service, General Managers, Heads of Nursing, Corporate Leads and other senior managers.	• Board member job descriptions. • Executive responsibilities chart (January 2012).
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).	• Revised Trust structure (CSC). • CSC management structure includes manager, Chief of Service (clinician) and Head of Nursing.	• Trust organisation chart • Trust committee structure
Quality is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions.	• Quality is an integral part of each Board meeting. • Quality is integral to the business planning process.	• Board Agenda. • Board minutes. • IBP
Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership.	• Governance and Quality Committee is a sub-Committee of the Board, held monthly and chaired by the Director of Nursing or Medical Director with Non-Executive Director membership. • Detailed reporting schedule and attendance record.	• G&Q Committee minutes and agendas • G&Q Committee reporting schedule and attendance record

SHA comments:

- We would like to see the executive responsibility chart and examples of the quality content of Board level job descriptions.
- The clinical leadership structure, and subcommittee structure describe clear routes for cascading responsibility and we would like to see the sub-committee and organisational charts.
- Board minutes reviewed showed that quality is a strong and integral element of each meeting but no examples could be seen of quality being considered in discussions of finance and workforce, for example.

Monitor's example of good practice	Position statement	Evidence
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.	• The Board has ratified the Risk Management Strategy and issues escalated through the Board Quality reports.	• Risk Management strategy and associated policies
- Processes are documented.		• Risk Management strategy and associated policies
- There are agreed rules determining which issues should be escalated.		• Risk Management strategy and associated policies
Robust action plans are put in place to address quality performance issues. With actions having:	• Monthly performance and quality exception reports to the Board outlining actions being taken to address quality issues. Followed up on a monthly basis • Patient Safety Action plan, monitored through the Patient Safety Working Group. • SIRIs monitored monthly at the Board and SIRG.	• Monthly Board reports • Board minutes • Patient Safety action plan and PSWG minutes • SIRG minutes
- Designated owners and time frames.		
- Regular follow-ups at subsequent Board meetings.		
Learnings from quality performance issues are well-documented and shared across the Trust on a regular, timely basis, leading to rapid implementation at scale of good-practice.	• SIRI and complaint investigation documentation. • The Trust run an Essential Update Programme and a Patient Safety Day for nursing staff which are used to refresh and update information that is essential for staff, which includes learning from risk and SIRIs etc.	• SIRI and complaint reports
There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns.	• Trust-wide Clinical Audit plan incorporating each CSCs audit programme, monitored through the Clinical Effectiveness Steering Group. • Clinical Audit Annual report discussed at the Audit Committee. • Clinical Audit database containing results of audits and re-audits. • Improvements from audits noted in quarterly quality Board report and Quality Accounts. • Results of National Audits monitored at the Clinical Effectiveness Steering Group. • Internal Audit reports reviewed at Audit Committee and RAC	• Clinical audit plan • CESG minutes • Audit Committee minutes • Clinical audit annual report • Board reports • Quality Accounts • RAC minutes
- Continuous rolling programme that measures and improves quality.		
- Action plans completed from audit.		
- Re-audits undertaken to assess improvement.		

Monitor's example of good practice	Position statement	Evidence
A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle.	• Whistleblowing policy available on Internet and Intranet.	• Whistleblowing policy • New whistleblowing number communication email
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.	• Monthly structured performance reviews for performance at CSC level. • Challenge of CSC performance at the monthly performance reviews • Clear appraisal policy and monitoring of individual performance (appraisal rate reported monthly to the Board). • Employee of the month • CEO weekly message and team brief praises individuals and teams • Messages in LINK	• APDR policy • Capability policy • CEO weekly message examples • Team brief • LINK • Action points arising from CSC performance reviews.
SHA comments: • While the Board are described as being clear regarding escalation – how are the Board assured that staff / committees are clear? Examples of issues being raised to the Board where the Board has had a positive impact on quality would add to the statements. • Has the whistleblowing policy been used and is this reported to the Board? What informal routes are there for raising concerns – open door policy etc. • Here and in other areas there may be evidence in your peer review in 2010; although some of this may need to be refreshed.		
3c: Does the Board actively engage patients		
Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance.	• Monthly and quarterly Board reports available on the Trust internet. • Published Board minutes. • Published Quality Account.	• Board reports • Board minutes • Quality Account
The Board actively engages patients on quality, e.g.:		•
- Patient feedback is actively solicited, made easy to give and based on validated tools.	• Real-time web-based patient feedback system (Optimum) in use. • Comments cards available at specialty and corporate level. Themes analysed at specialty and corporate level. Feedback via Patient Experience Steering Group (PESG) • Themed questions using counter system in traditionally difficult to access patient groups e.g. ED • Volunteers trained in use of securing feedback via surveys including telephone and face to face methods. • Successful innovation grant application to purchase mobile IT devices with	• Board reports • PESG minutes • CSC governance reports • Innovation grant funding letter

Monitor's example of good practice	Position statement	Evidence
	accessible information software to enable patient, relative and carer feedback from those with cognitive impairment.	
- Patient views are proactively sought during the design of new pathways and processes.	• Patient representation established in PESG, Patient Environment Partnership Group (PEPG), Hospital Food Committee, Band 3 and 4 Healthcare Support Worker working group and Mental Health and Learning Disability (MHLD) Committee. • Learning disability service users involved in evaluation of liaison service and development of care pathways. • LD and Adult Mental Health service users represented on innovation grant project group.	• Committee minutes • Evaluation report • Innovation grant project plan
- All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board.	• Patient feedback reviewed at CSC Governance Committees. • Patient feedback included in monthly and quarterly Board reports. • Director of Nursing personally reviews every patient complaint. • Patient feedback included in each CEO weekly message.	• CSC Governance minutes • Board reports • CEO weekly message
- The Board regularly reviews and interrogates complaints data.	• Complaints data included in monthly and quarterly Board reports. And reporting has changed following Board feedback.	• Board minutes • Board reports
- 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).	• Patient stories • Patient safety walkabouts (led by the NEDS) • Captains rounds • The monthly and quarterly Board reports provide information on patient experience and plaudits received.	• Board minutes • Patient safety walkabout programme • Monthly and quarterly Board reports.
The Board actively engages staff on quality, e.g.:		
- Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly 'temperature gauge' plus annual staff survey).	• Annual staff survey – communications from HR to encourage completion • Ongoing internal 'pulse' survey • CEO forum • Team brief • Safety walkabouts and Captains rounds – talk directly to staff	• HR communication • HR heatmap and Board report – pulse survey results • CEO forum invitation • Example of team brief
- All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board.	• Annual staff survey and action plan is reported to the Board • 2011 staff survey demonstrates a much improved position. • Pulse survey results reported monthly on the HR heatmap to the Board and to the CSCs	• Board reports

Monitor's example of good practice	Position statement	Evidence
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.	• Monthly and quarterly Board Quality reports reviewed by the Commissioners and issues addressed at CQRM	• CQRM minutes
- Feedback from PALS and LINKs is considered.	• Themes from PALS contacts are reported to the Board within the Quality reports. LINKs are also encouraged to provide feedback and this is also included in the Board Quality reports.	• Board Quality reports
- 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.	• Clinical Leaders Forum (involves GPs, PCT and the Trust) • Collaboration with partners e.g. Integrated Discharge Bureau (IDB)	• Clinical Leaders Forum minutes
- The Board is clear about Governors' involvement in quality governance.	• The Council of Governors meeting is attended by the Chairman, Chief Executive and Company Secretary. • The Trust has three sub-committees of the main Council of Governors meeting: Best Hospital, Best people and best care and Planning and performance. The minutes from these meeting are submitted to the main Council of Governors meeting. • A Governor is a member of the Governance and Quality Committee.	• Council of Governors meeting minutes

SHA comments:

- The range of methods used to gather patient views is positive and includes web based systems and comment cards. An example of improvement resulting from analysis of this information – and presentation to the Board – would give a complete picture. There are very clear priorities regarding this in the 2012/13 Operating Framework.
- The routes to gain staff feedback seem sound with annual survey supplemented by the internal 'pulse' survey. We are aware there has been much work to improve staff satisfaction but note in the Board report some areas including communication with senior management and staff remain rated as red. Is the Board confident this year's staff survey results will be improved? This would be a good area to demonstrate a completed action plan, results being monitored and further actions planned.

Monitor's example of good practice	Position statement	Evidence
4. Measurement		
4a. Is appropriate quality information being analysed and challenged?		
The Board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include:	• Monthly quality and performance dashboard containing key metrics reported to the Board.	• Monthly quality exception Board report (except GTT) • Monthly Board performance report. • Quarterly Quality Board report
- Key relevant national priority indicators and regulatory requirements.	• National targets and CQUIN requirements included • CQC compliance and QRP monitoring reported to the Board quarterly. CQC inspections reported as required to the Board through the monthly quality exception report.	
- Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each).	• Includes patient safety and experience metrics. • Need to include additional clinical effectiveness metrics once agreed for 2012/13.	
- Selected 'advance warning' indicators.	• The quality heatmap contains a number of metrics which act as an early warning system	
- Adverse event reports.	• SIRIs and patient safety incidents included in the monthly and quarterly Board reports	
- Measures of instances of harm (e.g. Global Trigger Tool).	• GTT reported quarterly to the Board not monthly	
- Monitor's risk ratings (with risks to future scores highlighted).	• Contained within monthly Board performance reports.	
- Where possible/appropriate, percentage compliance to agreed best-practice pathways.	• Included on performance dashboard e.g. stroke	
- Qualitative descriptions and commentary to back up quantitative information.	• Included in the monthly quality exception report	
The Board is able to justify the selected metrics as being:		
- Linked to Trust's overall strategy and priorities.	• These are dependant on the content of the Quality Account and Quality Contract (CQUIN). The full review of the heatmap is undertaken each year to reflect the Trust Quality priorities (outlined in the Quality Account and Quality Contract).	
- Covering all of the Trust's major focus areas.		

Monitor's example of good practice	Position statement	Evidence
- The best available ones to use.		
- Useful to review.		
The Board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines.	• Quarterly themed Board reports for safety, experience, clinical effectiveness and compliance. • CSCs report on quality to the Governance and Quality Committee. • Reports and data reviewed at the patient safety, experience and clinical effectiveness sub committees of Governance and Quality Committee and the Audit Committee. • CSC Quality dashboard reviewed at the Executive performance reviews. • Specialty governance reports discussed at CSC Governance Committees	• Quarterly Board reports • Sample of CSC governance reports • Minutes from CSC Governance Committees • Minutes from PSWG, PESG and CESG • Minutes from Governance and Quality Committee • Minutes from Audit Committee
Quality information is analysed and challenged at the individual consultant level.	• Audit leads are invited to the CESG to discuss the outcomes of National and Local Audits. Challenge will occur at these meetings as appropriate. • The Trust provides protected time for all consultants to attend clinical governance meetings where quality information is discussed • Challenge will also be provided at Consultant annual appraisals.	• Clinical Effectiveness Steering Group Minutes. • Consultant job plans (time for governance)
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 quality Board heatmap is reviewed monthly • Following review an additional patient experience metric included in the December quality heatmap. • The full review of the heatmap is undertaken each year to reflect the Trust Quality priorities (outlined in the Quality Account and Quality Contract).	• Monthly quality exception Board report

SHA comments:

- The assessment of the Trusts quality dashboard against the criteria set out by Monitor is a sound approach; however there are several examples where the self assessment states this is done in a different place or with a different frequency. The Trust should be able to demonstrate a clear rationale that shows why doing it differently is a better approach – or a plan to change.
- Once a vision and strategic aims are available in the IBP you will be able to show that the measures clearly support your stated priorities.
- The statement "The Board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines." Is evidenced by reference to a selection of minutes. For those assessing and to give your Board assurance it may be clearer to give a specific example showing an issue being reported at CSC level in detail, being part of a sub committee agenda, then feeding in to the Board report.
- We note you refer to the update and review of the dashboard and mention the refresh of the clinical effectiveness content. We would recommend you

Monitor's example of good practice	Position statement	Evidence
consider the readmissions as your high rate nationally will be noted by the DH and Monitor on application. • We were not clear where or how the Board are assured regarding CQC compliance.		
4b: Is the Board assured of the robustness of the quality information?		
There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness.	• The Trust has a data quality policy that is enforced by the data quality group • The Trust data quality web page includes reports on coding completeness, missing data fields and incorrect data	• Minutes from data quality group • Intranet reports
- Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the Board of the quality of its data.	• Each CSC is represented on the data quality group • Data quality is reported at CSC level and the top 5 risks as well as coding completeness are included in the monthly CSC heat-maps and discussed at monthly review meetings with executive management team	• Minutes from data quality group • CSC level heat-maps
- 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).	• Clinical audit forward audit plan based on local and National priorities • Clinical audit policy outlining process • Additional audits undertaken as a result of identification of local risks e.g. handover, pressure ulcers, risk assessment	• Forward audit plan and priorities list • Clinical audit policy • Audit examples
- Electronic systems are used where possible, generating reliable reports with minimal ongoing effort.	• Datix provides data for BI pack • Chimera provides data for Board to ward clinical dashboard • Others are provided using reporting tools which take information direct from the trusts PAS system and VitalPAC	
- Information can be traced to source and is signed-off by owners.	• All PAS transactions can be traced to individual users. • All external reporting is sense checked for accuracy against previous submissions by manager responsible and agreed with head of business intelligence. • All new reporting is tested for accuracy and data completeness by BI managers and with clinical teams using national benchmarking if appropriate. • Data submissions for the Quality Account are supported by completion of a data validation form as outlined in the Quality Account Process document	• TRL logs • Quality Account process document
There is clear evidence of action to resolve audit concerns.	• Internal and external audit recommendations are reviewed at each Audit Committee. • National Audits are reviewed at the CESG and reported quarterly to the Board, through the Clinical Effectiveness Board report.	• Audit Committee minutes • Corporate diaries • Board minutes • CESG minutes • Quarterly Board reports

Monitor's example of good practice	Position statement	Evidence
- Action plans are completed from audit (and subject to regular follow-up reviews).	• Clinical audit database includes CSC/specialty action plans from local and National audits and this is monitored through CESG. • Internal and external audit recommendations are reviewed at each Audit Committee.	• CESG minutes • Audit Committee minutes
- Re-audits are undertaken to assess performance improvement.	• Re- audits are undertaken to demonstrate improvements.	• Examples of re-audits e.g. ward assessment audit (outcome 4), NPSA audits, MUST
There are no major concerns with coding accuracy performance.	• The clinical coding manager undertakes a bi-monthly audit of accuracy, which will be reported quarterly through the Board Quality Report and quarterly to CESG. • Coding accuracy is reviewed by external audit on a regular basis and outcomes reported to senior management team.	• Evidenced from Q4 onwards • Coding accuracy external audits
SHA comments: • The key to a good response would then be the Boards ability to identify these strands when asked about assurance of information in quality reports, and in the robustness of the processes used by these groups and committees. The response of the Board can be tested at Board to Board meetings, but we would find it useful to see some evidence supporting this area.		
4c. Is quality information being used effectively?		
Information in quality reports is displayed clearly and consistently.	• Quality data is presented to the Board in the same format and layout monthly and quarterly. The priorities are clearly defined e.g. National, CQUIN, Quality Account. It is acknowledged that the reports are public documents and are written accordingly.	• Board reports
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).	• Targets are included where relevant on the quality heatmap contained within the monthly Board quality exception report. All indicators within the heatmap are RAG rated accordingly and provide information for each quarter and monthly during the quarter. • The narrative within the Board reports are explicit as to whether there is a target and if so where the target originated (i.e National target, CQUIN, Quality contract, Quality Accounts). • The Trust uses a variety of information to compare own performance over time and against external benchmarking. Such information includes patient surveys (i.e. in-patient survey, out-patient survey, ED survey). The results are reported to the Board through the quarterly reporting schedule and ad-hoc as appropriate. • External information has been provided by the McKinsey Hospital Institute	• McKinsey Hospital Institute information. • Quality observatory dashbaord • In-patient survey • Out-patient survey • ED survey • Maternity survey • Monthly Board Quality Exception reports. • Quarterly Board reports.

Monitor's example of good practice	Position statement	Evidence
	and reported to the Board. • Quarterly themed Patient Experience Board reports, contains 'rag' rated information (now incorporated in the Quarterly Board Quality Account). • Performance on National Audits, including benchmarking is contained within the Clinical Effectiveness section of the new Quarterly Board Quality Account (previously as a quarterly themed Board report). • The Trust is reviewing the data recently published by the Quality Observatory.	
Information being reviewed must be the most recent available, and recent enough to be relevant.	• Data presented to the Board is currently 6 weeks in arrears due to the current paper system in use (Datix web project currently underway which will help to resolve this issue). This is currently under review. • The results of National Audits are discussed at the CESG the month following publication. The Board are made aware of results and actions through the quarterly Quality Board reports.	• Monthly Board Quality Exception reports. • CESG reports
'On demand' data is available for the highest priority metrics.	• Business intelligence are able to provide key performance data on request. • Some performance data is available on demand, such as ED breaches. • Datix can be interrogated but acknowledged that data is approximately 6 weeks in arrears due to current paper system in use (Datix web project currently underway which will help to resolve this issue)	
Information is 'humanised' /personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate).	• As well as the total number, of SIRIs, a brief description (i.e. patient fall, maternity incident, pressure ulcer) is provided in the monthly public Board quality exception report. The monthly private Board quality report provides additional information, by way of a full summary of all SIRIs. • A SIRI notification email is sent to the Board and other key staff after each SIRI which outlines the incident. • Complaints information contained within the monthly Board quality exception report provides a breakdown of the top 5 complaints by CSC and a comparison of themes each month, rather than just providing the number of complaints. • CEO weekly message makes reference to specific individuals and the care they received.	• Monthly Board Quality Exception reports. • CEO weekly message • SIRI email
Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance.	• Clear actions taken as a result of Board challenge e.g. VTE risk assessment, C.Diff, pressure ulcers. • VTE Risk Assessment: - Through monitoring, it was identified that the Trust was not achieving the VTE risk assessment target. An e-mail to all clinical staff was sent on the	• All clinical staff e-mail regarding VTE risk assessment (13.07.11) • Director of Nursing e-mail regarding VTE risk

Monitor's example of good practice	Position statement	Evidence
	13.07.11 reminding staff of the requirement that assessments must be completed electronically through VitalPac, and who is able to complete the assessment. - The Director of Nursing sent an e-mail to all appropriate staff (19th August 2011) requesting that systems be put in place to provide assurance that all patients receive an assessment. - Subsequently, VTE risk assessment completion has improved and the target of 90% is being met. • Performance and quality metrics are reported to the Board on a monthly and quarterly basis and actions to address any areas of low/non compliance is outlined in the reports. For example, improvements seen in stroke targets, reduction in the severity of patient falls, reduction in grade 3 and 4 pressure ulcers. • CSCs hold specialty performance reviews where compliance is challenged and review of quality using the clinical dashboard. • Executive performance reviews with each CSC are held monthly and review a quality heatmap to address areas of concern.	assessment (19.08.11). • Board reports • CSC heatmaps and actions from performance reviews

SHA comments:

- The Board reports reviewed at very clearly showed performance against targets however performance against external benchmarks was less obvious. The review indicates this is clear in the new clinical effectiveness section of the quarterly report and it would be useful if we could see this.
- The examples of actions to improve performance include very specific dated emails. This approach is very clear and it may be in evidence for some other areas; specific dated, numbered minutes would be easier to identify.
- Mention of external reports e.g. McKinsey can only strengthen the evidence.

The gap analysis above, was discussed at a Board workshop on 5th April 2012 whereby the Board agreed the following risk rating.

10 key questions		Score
Strategy		
1a	Does quality drive the Trust's strategy?	**0.5**
1b	Is the Board sufficiently aware of potential risks to quality?	**0.5**
Capabilities and Culture		
2a	Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	**1.0**
2b	Does the Board promote a quality-focused culture throughout the Trust?	**0.5**
Processes and Structures		
3a	Are there clear roles and accountabilities in relation to quality governance?	**0.0**
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**0.0**
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	**1.0**
Measurement		
4a	Is appropriate quality information being analysed and challenged?	**1.0**
4b	Is the Board assured of the robustness of the quality information?	**0.5**
4c	Is quality information used effectively?	**0.5**
Trust Score		**5.5**

Risk rating matrix

Score	Risk rating	Definition	Evidence
0	Green	**Meets** or **exceeds** expectations	**Many elements** of good practice **+ no major omissions**
0.5	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	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	Red	Does not meet expectations	**Major omission in quality governance identified** **+ significant volume of action plans** required, **concerns on management delivery capacity**

- Authorisation criteria is a score of 3.5 or less.
- Quality Governance score of 4 or worse cannot be authorised.
- Overriding rule states no section can be rated entirely Amber/Red.

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
3. Strategy				
1a. Does quality drive the trust's strategy?				
• Quality is embedded in the Trust's overall strategy. - 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. - Quality goals reflect local as well as national priorities, reflecting what is relevant to patients and staff. - Quality goals are selected to have the highest possible impact across the overall Trust. - Wherever possible, quality goals are specific, measurable and time-bound. - Overall Trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service). - There is a clear action plan for achieving the quality goals, with designated lead and timeframes. • Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the Trust and the community it serves. • The Board regularly tracks	Further promote the Quality Improvement Strategy.	Head of Governance	May 2012	**Complete** (various communications ongoing). CEO weekly message and Trust intranet news page May 12.
	Improve communication regarding quality priorities and goals to all levels of staff (Trust-wide).	Head of Governance	May 2012	**Complete but on-going communications required** Discussed at the CESG, PSWG and CESG. Will be included in June team brief and nurse preceptorship training. Requested that Heads of Nursing riase at each CSC Governance Committee.
	Develop and undertake a survey to gain assurance of staff understanding of quality goals.	Head of Governance	July 2012	
	Review CSC Governance agenda templates to ensure discussion regarding key quality priorities.	Head of Governance	May 2012	**Complete**
	Bi-annual audit of CSC Governance Committee agendas and minutes.	Head of Governance	July 2012 January 2013	
	Review the Trust quality heatmap to ensure focus on internal as well as external quality targets.	Director of Nursing	May 2012	**Complete.** Quality heatmap revised to include National and local priorities. Will be further developed with the

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
performance relative to quality goals.				implementation of the Integrated Performance Board report
	Implementation of the CSC Performance Assurance Framework.	A. Glen	June 2012	
	Develop action plans to ensure the delivery of quality goals through the appropriate sub-committees of Governance and Quality Committee.	Chair of PSWG, PESG, CESG.	May 2012	**Complete for PSWG and PESG. Outstanding action for CESG.** PSWG action plan developed and going to PSWG in June for agreement. PESG ToR amended to reflect priorities and reporting template inclusive of all reporting requirements. To be ratified 11 June. CESG – process to be agreed at June meeting.
	Review CSC processes for dissemination of quality goals.	Head of Governance	June 2012	
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.	Develop a CIP process document to include process for ongoing monitoring, risk impact assessment and impact on quality and other services.	Director of Nursing and Medical Director	May 2012	**Complete.** Quality Impact assessment (QIA) forms developed and implemented. DoN/MD

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
• The Board regularly reviews quality risks in an up-to-date risk register. • The Board risk register is supported and fed by quality issues captured in directorate/service risk registers. • The risk register covers potential future external risks to quality (e.g. new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks. • There is clear evidence of action to mitigate risks to quality. • Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment). • 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). - Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality). - Historical evidence illustrating prior experience in making operational	Develop CIP sign off template (to be included in process document)			viewed all CIP plans. DoN sits on CIP/Transformation Committee where the CIP QIA are reviewed
	Bi-annual audit of CIP process to ensure CIPs identified in-year are authorized by the Medical Director and Director of Nursing (consistent process).	Director of Finance	July 2012 January 2013	
	Ensure CIP risks are included on CSC risk registers and Trust Risk Register as appropriate, and reviewed monthly through CSC Governance Committees (links to action above to review and audit CSC Governance Agenda templates).	Head of Risk Management and Legal Services	On-going	
	Ensure a log of all CIPs is maintained and reviewed.	Director of Finance	On-going	
	Review the Trust Risk Register to ensure all appropriate risks are recorded and those risks which threaten the strategic objectives are also included on the Assurance Framework (currently two separate documents).	Head of Risk Management and Legal Services	June 2012	
	Ensure risk management policy/strategy reflects the above.	Head of Risk Management and Legal Services	June 2012	
	Ensure any risks (internal or external) that are identified through the IBP development are considered and acted on appropriately.	Brian Courtney / Company Secretary	On-going	
	Provide evidence of how learning from SIRIs is shared and monitored across the Trust.	Head of Risk Management and Legal Services	June 2012	

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints). • The Board is assured that initiatives have been assessed for quality. • All initiatives are accepted and understood by clinicians. • There is clear subsequent ownership (e.g. relevant clinical director). • There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistleblower policy. • Initiatives' impact on quality is monitored on an ongoing basis (post-implementation). • Key measures of quality and early warning indicators identified for each initiative. • Quality measures monitored before and after implementation. • Mitigating action taken where necessary.	Review processes for escalation of risk with non-achievement of quality goals.	Head of Governance	May 2012	**Complete.** Responsible committees identified for monitoring of all quality priorities. CQUIN indicators being monitored monthly (and weekly where possible). CSC performance framework revised and facilitates escalation of risk to the executive team. Income protection meeting fortnightly to monitor CQUIN compliance.
4. Capabilities and culture				
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	Evidence of implementation of the Board development programme.	Company Secretary	To be confirmed	
	Arrange Board observations.	Brian Courtney	First held 26.4.12. Others to be arranged	
	Mock Board to Board.	Brian Courtney	To be	

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
and sub-committees). • The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board. • Board members are able to: - Describe the Trust's top three quality-related priorities. - Identify well- and poor-performing services in relation to quality, and actions the Trust is taking to address them, - Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures). - Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them. - Be clear about basic processes and structures of quality governance. - Feel they have the information and confidence to challenge data. - 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. • 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			confirmed	
	Peer review by others.	Brian Courtney	To be confirmed	
	Non Executive shadowing from another Trust.	Brian Courtney	To be confirmed	

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
on quality). • The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained. • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.				
2b. Does the Board promote a quality-focused culture throughout the organisation?				
• The Board takes an active leadership role on quality. • The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations). • The Board regularly commits resources (time and money) to delivering quality initiatives. • The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members). • The Board encourages staff empowerment on quality. • Staff are encouraged to participate in quality / continuous improvement training and development. • Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment). • Staff are entrusted with delivering the quality improvement initiatives they	Provide specific examples of Executive and NED leadership on quality improvement.	Director of Nursing	July 2012	**Complete.** Liz Conway (NED): Chair of Organ Donation Committee. Member of PSWG. Mark Nellthorpe: Member of Governance and Quality Committee. Alan Cole: Chairs Audit Committee. Reviews CQC compliance Steve Erskine: Member of Audit Committee. Patient Safety walkabout process development. Simon Holmes: infection prevention and vascular. Robert Toole: Estates and sewage Julie Dawes: Pressure ulcers, VTE, WHO checklist.

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
have identified (and held to account for delivery). • Internal communications (e.g. monthly news letter, intranet, notice boards) regularly feature articles on quality.				Patient safety walkabout action log – provides examples of Board leadership on quality issues.
	Increase frequency of internal staff survey results reported to the Board.	Director of Workforce and Organisational Development	May 2012	**Complete** Pulse survey results are reported monthly to the Board. Action plans against the National Staff Survey will be reported quarterly.
	Provide evidence of staff empowerment to deliver quality improvement iniatives e.g. butterfly scheme in ED.	Head of Governance	June 2012	
	Introduce a quality mailbox for staff feedback and suggestions.	Head of Governance	June 2012	
	Roll-out of safety culture questionnaire (MaPSaF).	Head of Governance	June 2012	
	Increase benchmarking data in quarterly quality account Board reports.	Head of Governance	July 2012 and quarterly	
	Determine how the patient perspective is added to the themes and trends presented to the Board (patient story at Board meetings).	Director of Nursing	May 2012	**Complete** Discussion with Chairman on 1 June 2012. Now need to bring a story to each Board meeting. Agreed would go to private part of the Board. To look at case study, video, patient attendance.

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
	Provide examples of how risk management training is used in practice.	Head of Risk Management and Legal Services	August 2012	
3. Structures and processes				
3a. Are there clear roles and accountabilities in relation to quality governance?				
• Each and every board member understands their ultimate accountability for quality. • There is a clear organisation structure that cascades responsibility for delivering quality performance from 'Board to ward to Board' (and there are specified owners in-post and actively fulfilling their responsibilities). • Quality is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions. • Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership.	Agree Board sub-committee structure.	Company Secretary	July 2012	
	Provide examples at Board meetings where quality is discussed in relation to finance and performance through Board observation.	Company Secretary	July 2012	
	Review CSC and corporate organisation charts to ensure lines of accountability are clear.	Chief Operating Officer	July 2012	
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	Provide examples of where risks or concerns identified by staff and/or committees have	Company Secretary	July 2012	

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
issues to the Board. - Processes are documented. - There are agreed rules determining which issues should be escalated. • 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. • Learnings from quality performance issues are well-documented and shared across the Trust on a regular, timely basis, leading to rapid implementation at scale of good-practice. • There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with	been escalated to the Board and the Board have had a positive impact.			
	Further CSC education regarding risk scoring to improve consistency.	Head of Risk Management and Legal Services	July 2012	
	Ensure HR reporting to the Board covers the number of whistle-blowing cases per quarter and details as appropriate.	Director of Workforce and Organisational Development	July 2012	**Complete** Whistle blowing cases are included in the Private Board report
	Develop process for logging informal concerns raised by staff.	Director of Workforce and Organisational Development	August 2012	More work is required to develop this with potential to use social media more effectively
	Review staff education on raising concerns.	Director of Workforce and Organisational Development	August 2012	Current review of induction has highlighted insufficient focus in educating staff on whistle blowing policy. This is in the process of being updated

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
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. • A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle. • 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.				
3c: Does the Board actively engage patients				
• Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance. • The Board actively engages patients on quality, e.g.: - Patient feedback is actively solicited, made easy to give and based on validated tools. - Patient views are proactively sought during the design of new pathways and processes. - All patient feedback is reviewed on	Improve reporting of staff concerns to the Board (linked to 3b).	Director of Workforce and Organisational Development	August 2012	Once the work in 3b above is completed this will be included in the Private Board report

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
an ongoing basis, with summary reports reviewed regularly and intelligently by the Board. - The Board regularly reviews and interrogates complaints data. - The Board uses a range of approaches to 'bring patients into the Board room' (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing). • The Board actively engages staff on quality, e.g.: - Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly 'temperature gauge' plus annual staff survey). - All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board. • The Board actively engages all other key stakeholders on quality, e.g.: - Quality performance is clearly communicated to commissioners to enable them to make educated decisions. - Feedback from PALS and LINKs is considered. - For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway.				

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
- The Board is clear about Governors' involvement in quality governance.				
4. Measurement				
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. - Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each). - Selected 'advance warning' indicators. - Adverse event reports. - Measures of instances of harm (e.g. Global Trigger Tool). - Monitor's risk ratings (with risks to future scores highlighted). - Where possible/appropriate, percentage compliance to agreed best-practice pathways. - Qualitative descriptions and commentary to back up quantitative information. • 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	Identify CSC hotspots in Board reports.	Head of Governance	May 2012 and on-going	**In development** Being developed as part of the Integrated Performance Board report and CSC Performance Framework
	Specific example showing an issue being reported at CSC level in detail, being part of a sub-committee agenda, then feeding in to the Board report.	Head of Governance	June 2012	
	Review of the quality dashboard to be presented to the Board (linked to 1a).	Director of Nursing	May 2012	**Complete.** Revised heatmap for presentation at the Board meeting in May
	Strengthen quality reporting to the Board to be inclusive of CSC level data. This will ensure risks to quality at CSC level are identified readily.	Head of Governance / A. Glen	July 2012	

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
focus areas. - The best available ones to use. - Useful to review. • The Board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines. • Quality information is analysed and challenged at the individual consultant level. • The Board dashboard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the Board commits time and resources to developing new metrics.				
4b: Is the Board assured of the robustness of the quality information?				
• There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness. - Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the Board of the quality of its data. - Clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents). - Electronic systems are used where possible, generating reliable reports	Obtain assurance that gaps in data quality are identified, escalated and reported appropriately.	Director of Finance	To be confirmed	

Monitor's example of good practice	Action	Responsible Lead	Deadline	Progress update May 2012
with minimal ongoing effort. - Information can be traced to source and is signed-off by owners. • There is clear evidence of action to resolve audit concerns. - Action plans are completed from audit (and subject to regular follow-up reviews). - Re-audits are undertaken to assess performance improvement. • There are no major concerns with coding accuracy performance.				
4c. Is quality information being used effectively?				
• Information in quality reports is displayed clearly and consistently. • 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). • Information being reviewed must be the most recent available, and recent enough to be relevant. • 'On demand' data is available for the highest priority metrics. • Information is 'humanised' /personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate). • Trust is able to demonstrate how reviewing information has resulted in actions which have successfully	Provide evidence that benchmarking data is reviewed at detailed level regularly i.e. not just at Board level.	Chief Operating Officer / A.Glen	July 2012	
	Evidence of external review of data and actions taken as a result (e.g. McKinsey's).	Director of Finance	To be confirmed	

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improved quality performance.				