SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST O

EXECUTIVE SUMMARY
REPORT TO THE BOARD OF DIRECTORS
19 OCTOBER 2011

Subject:	Quality Governance Review Final Report
Supporting Director:	Mike Richmond, Medical Director
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PURPOSE OF THE REPORT:

Final Report of the Quality Governance Review using Monitor's Quality Governance Framework in order to provide assurance to the Board of Directors to enable submission of a revised Board Statement to Monitor by Quarter 2 submission date.

KEY POINTS:

- Monitor's 2011/12 Compliance Framework required Boards to confirm in their Board Statements submitted as part of the 2011/12 annual planning process that it has regard to Monitor's Quality Governance Framework (QGF).
- As the Trust had not assessed its quality governance against the QGF, it submitted an interim Board Statement with a stipulation that it would be in a position to submit the revised statement by Q2 submission i.e. 31/10/2011
- At its July meeting, the Board approved proposal to undertake an in-depth review of quality governance using the QGF and to establish a steering group to lead the review.
- The Quality Governance Steering Group was established as a task and finish committee of the Board.
- The Steering Group approved
    - a Quality Governance Analysis tool (an adaptation of the QGF) to document evidence of the Trust's position against the 10 core questions in the QGF
    - a rating scale used by Monitor to assesses quality governance in applicant trusts
- For each of the 10 questions in the QGF, the group identified leads to populate the analysis tool with evidence of the Trust's current position.
- The Steering Group made a summative assessment of documented evidence of STH practice against best practice examples and assigned a risk rating and score using Monitor's rating scale i.e. Green (0); Amber/Green (0.5); Amber/Red (1.0); and Red (4.0)
- The Steering Group assessment of quality governance gave an overall score of 3.0 and fell below Monitor's threshold for refusing authorisation i.e. an overall score of 4 or worse and no category rated entirely Red/Amber.
- Nonetheless, the review process identified a number of shortfalls that require further work to further strengthen the Trust's quality governance and the report includes an action plan comprising four recommendations focused on a refresh of the corporate strategy and the development and approval of a complementary Quality Strategy by March 2012.
- Primary and Community Services Group has undertaken a retrospective review of the documented evidence in the Quality Governance Analysis and confirmed that it is equally applicable.
- The review findings have been shared with a small group of Governors.
- As a task-and-finish group, the last meeting of the Quality Governance Steering Group will be on 1st November to finalise monitoring arrangements for the action plan.

IMPLICATIONS:

Achieve Clinical Excellence	To enhance the effectiveness of quality governance
Be Patient Focussed	As above
Engaged Staff	As above

RECOMMENDATION(S):

The Board of Directors is asked to **APPROVE** the Quality Governance Steering Group's assessment of the Trust's quality governance and their recommendation to the Board of Directors that the revised Board Statement is submitted to Monitor by 31 October 2011.

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS
19 October 2011

QUALITY GOVERNANCE REVIEW

FINAL REPORT

Background

Following events at Mid-Staffordshire, Monitor undertook a review of its assessment process for applicant Foundation Trusts. After a consultation exercise it published a *Revised Guide for Applicants* in July 2010 which requires applicants to provide a Board Memorandum detailing its arrangements for quality governance using Monitor's *Quality Governance Framework*.

The change to the assessment process signalled Monitor's commitment to give equal weighting to Quality Governance and Financial Governance.

This principle was incorporated into the 2011/12 Compliance Framework which included a number of material changes to the way Monitor measures and assesses governance and financial risk for existing FTs. Specifically, the Compliance Framework required Boards to confirm that they have regard to the *Quality Governance Framework* as part of the 2011/12 annual planning process.

2011/12 Board statements

As part of it's 2011/12 Annual Plan submission to Monitor, the Trust was unable to confirm a key revised Board Statement i.e. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS Foundation Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* The Trust has not assessed its quality governance against the *Quality Governance Framework*.

In accordance with Monitor guidance, the Trust submitted an interim statement (as per 2010/11 statement) with a stipulation that actions would be taken in order to be in a position to make the revised statement by Quarter 2 submission i.e. 31 October 2011.

Quality Governance

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

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

[NB The National Quality Board updated it's report *Quality Governance in the NHS – a guide for provider boards* adopting Monitor's definition of quality governance and the Quality Governance Framework as the basis of their guidance on how to govern for quality.]

Quality Governance Framework

The *Quality Governance Framework* (re-published July 2011) is an assessment tool for Boards to review their governance arrangement to ensure essential levels of quality and safety are met and to drive forward continuous improvement. The framework sets out 10 key questions underpinning four categories of quality governance – see below:

Category	Questions	
Strategy	Q1	Does quality drive the trust's strategy?
	Q2	Is the board sufficiently aware of potential risks to quality?
Capabilities and culture	Q3	Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?
	Q4	Does the board promote a quality-focused culture throughout the trust?
Process and structure	Q5	Are there clear roles and accountabilities in relation to quality governance?
	Q6	Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
	Q7	Does the board actively engage patients, staff and other key stakeholders on quality?
Measurement	Q8	Is appropriate quality information being analysed and challenged?
	Q9	Is the board assured of the robustness of the quality information?
	Q10	Is quality information used effectively?

Against each question the framework includes a number of good practice examples for Board's to use in assessing their practice.

STH Review of Quality Governance

In July 2011, the Board of Directors approved a paper recommending the Trust

- undertake an in-depth review of the Trust's quality governance arrangements using the Quality Governance Framework (QGF).
- establish a steering group to lead the review.

a) <u>Quality Governance Steering Group</u>

(i) The Steering Group was established as a task-and-finish committee of the Board of Directors.

(ii) The group is chaired by a Non-executive Director. Membership includes the Chief Nurse/Chief Operating Officer, the Medical Director, the Director of Service Development and the Trust Secretary. The Head of Patient and Healthcare Governance, the Assurance Manager and the Service Development Director are in attendance.

b) <u>Review process</u>

(i) At the inaugural meeting on 10 August, the Steering Group approved

- a Quality Governance Analysis tool (an adaptation of the QGF) to document evidence of the Trust's position against the 10 core questions
- a rating scale developed by Monitor when assessing quality governance in applicant Foundation Trusts.

(ii) For each of the 10 questions the group identified a lead member to populate the Quality Governance Analysis tool with evidence of compliance using the good practice examples.

(iii) The completed Quality Governance Analysis (Appendix 1) was circulated for the next meeting of the Steering Group.

(iv) At the Steering Group meeting on 20 September, relevant leads gave a verbal update on the section evidence and the group made a summative assessment of documented evidence of STH practice against best practice examples and assigned a risk rating to each of the 10 key questions using the Monitor scale[1], as detailed in the table below.

Risk Rating (Score)	Definition	Evidence
Green (0)	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber/Green (0.5)	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and robust action plans in place to address perceived shortfalls and proven track record of delivery
Amber/Red (1.0)	Partially meets expectations but some concerns on management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development and limited evidence of delivery in past.
Red (4)	Does not meet expectations	Major omission in Quality Governance identified. Significant volume of action plans required and concerns on management capacity to deliver

c) Findings

Once all 10 components had been risk rated and scored, the total score for the Trust was calculated, see table below:

Category	Questions		Rating	Score
Strategy	Q1	Does quality drive the trust's strategy?	Amber/Green	0.5
	Q2	Is the board sufficiently aware of potential risks to quality?	Amber/Green	0.5
Capabilities and culture	Q3	Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	Amber/Green	0.5
	Q4	Does the board promote a quality-focused culture throughout the trust?	Amber/Green	0.5
Process and structure	Q5	Are there clear roles and accountabilities in relation to quality governance?	Green	0
	Q6	Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	Green	0
	Q7	Does the board actively engage patients, staff and other key stakeholders on quality?	Amber/Green	0.5
Measurement	Q8	Is appropriate quality information being analysed and challenged?	Green	0
	Q9	Is the board assured of the robustness of the quality information?	Green	0
	Q10	Is quality information used effectively?	Amber/Green	0.5
			Total score	**3.0**

[1] Quality Governance Rating Scale (Guide for Applicants, Monitor. July 2010)

The Steering Group adopted Monitor's authorisation criteria when reviewing the overall assessment of the Trust's Quality Governance. i.e. to be authorised an applicant must demonstrate a Quality Governance Score of **less than 4** with an overriding rule that **none of the 4 categories of Quality Governance can be entirely Amber/Red rated**.

d) Action Plan

Although the Steering Group assessment did not meet the criteria for refusing authorisation, the review process did identify a number of shortfalls that require further work to further strengthen the Trust's quality governance.

The key actions with identified leads and timescales are outlined below:

Recommendation	Lead	Deadline
Refresh the Corporate Strategy	KM	03/2012
Development of a Quality Strategy	MR	03/2012
December Board Strategic Session to discuss the development of the Quality Strategy and how it will fit with the Corporate Strategy and Group/Directorate Strategies.	NR	15/12//2011
Corporate Strategy, Quality Strategy and Group/Directorate Strategies in place.	KM	06/2012

e) Community Services

In response to a request by the Steering Group, the newly formed Primary and Community Services Care Group has undertaken a retrospective review of the documented evidence in the Quality Governance Analysis and has confirmed that it is applicable to the care group.

f) Feedback to Governors

As a committee of the Board of Directors, the Steering Group considered it inappropriate to include a Governor as a member but acknowledged the value of involving Governors in the process. On completion of the review, the Chairman of the Steering Group and the Trust Secretary met with four Governors on 10th October to discuss the review findings. The Governors were content with the process and outcome of the review and made constructive and supportive comments on a wide range of issues which it was agreed would be addressed in the development of the Quality Strategy.

g) Action Plan monitoring

The Steering Group's final meeting will be on 1st November (i.e. following submission of the revised Board Statement) to finalise monitoring arrangements for the action plan.

Recommendation

The Board of Directors are asked to **APPROVE** the Quality Governance Steering Group's assessment of the Trust's quality governance and action plan and submission of the revised Board statement to Monitor.

Vic Powell (Chair)
Quality Governance Steering Group

October 2011

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

MONITOR - QUALITY GOVERNANCE ANALYSIS

1 STRATEGY

Question	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
1a Does quality drive the Trust 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.	KM JM SC	The Corporate Strategy for 2009 to 2012 set goals for improving the care delivered to patients and in building capacity and capability in the workforce as well as relationships with partners. The Corporate Strategy resulted from a consultation with staff and stakeholders and was published in 2009. Progress was reviewed including through the Quality Reports in 2009/10 and 2010/11[2]. The most recent Quality Report identifies five quality improvement priorities for 2011/12, derived from the strategic direction and on-going review of services:- 1. Improving the care received by older people using our services 2. Improving the diagnosis and treatment of Venous Thrombo-embolism 3. Reducing hospital acquired infection 4. Continued improvement in stroke care services 5. Reducing the number of operations cancelled for non-clinical reasons Each of these areas of improvement has measurable outcome indicators to track improvement in quality. They are formally reported at least four times a year and will be incorporated into the 2011/12 Quality Report, which is a public document. The new 5 year strategic direction for 2012 to 2017 is under development and will be considered by the Trust Board in 2012. The process for building the next strategic direction is a fully engaged one, which involves patients, governors, staff and stakeholders.
			It will incorporate an overall strategic direction for the organisation, set down by the Trust Board to guide the organisation and provide a framework for further improving quality. It will then be built from the bottom of the organisation upwards through the development of strategic plans at Clinical Directorate level, which focus on quality including, patient safety, clinical effectiveness and the patient experience. The strategic direction will focus on quality and the five domains for improving clinical outcomes: 1. Enhancing quality of life for people with long term conditions 2. Preventing people from dying prematurely 3. Helping people to recover from episodes of ill health or following injury 4. Treating and caring for people in a safe environment and protecting them from harm 5. Ensuring people have a positive experience of care

APPENDIX I

[2] Not including Primary and Community Services Care Group

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
1a cont/d Does quality drive the Trust strategy	• Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff.	KM JM SC	The development of strategic plans at Clinical Directorate level will include the development of local outcome indicators that are set by local clinical teams actually working in the service concerned. The national outcome targets will be an essential part of the delivery framework but these will increasingly be supplemented by meaningful local outcome indicators.
			Quality Report Priorities for 2011/12: Five priorities identified though stakeholder engagement. Evidence of year on year improvements. Priorities linked to national (e.g. Stroke) and local (e.g. Cancelled operations) service improvement initiatives.
	• Quality goals are selected to have the highest possible impact across the overall Trust.		The hospital services will derive quality goals from direct feedback from patients and carers about the quality of the patient experience. In addition the hospital services bring together a quality dashboard of meaningful information to help to guide attention on quality improvements. A suite of quality indicators for each ward area is considered each month currently and action taken where indicators are of concern. The reporting framework through the corporate governance structure is in place. Commissioners are setting quality outcome targets in line with population need and the introduction of CQUINS and Best Practice Tariff payments will drive up quality. Continuous improvement is supported by incentives to improve quality that are then made sustainable within services. The Quality Report provides the year on year published assessment about how the Trust is doing against the Quality Improvements it has set.
	• Wherever possible, quality goals are specific, measurable and time-bound		The Quality Report for 2011/12 includes specific, measurable and time bound indicators for improvement. The Annual Plans, linked to the new strategic direction, will also include these.
	• Overall trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service).		The new strategic direction includes the five outcome domains that are specified by the NHS Commissioning Board. The contribution of each Clinical Directorate to these outcome domains will be made specific within the individual Clinical Directorate strategic plans.
			VTE Quality Report Priority 2011/12: VTE risk assessment compliance reported by area and discussed at Operation Board. (SC)
	• There is a clear action plan for achieving the quality goals, with designated lead and timeframes.		There is a clear action plan with named leads at Director and Service levels in the Quality Report for the priority areas for 2011/12. The development of the strategic plans at Clinical Directorate level for 2012 to 2017 will include designated leads and timeframes for delivery.
			Quality Report Priorities 2011/12: Each objective had an operational and executive lead with timeframes for achievement.

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
1a cont/d Does quality drive the Trust strategy	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 performance relative to quality goals.	KM JM SC	The Transforming Our Services Vision Framework, which has been used to identify the work streams flowing from Transforming Community Services, includes benefits and communication plans for the community of stakeholders who are involved. This approach will be replicated across all Clinical Directorates and progress reported through the relevant governance processes and to the Trust Board as appropriate.
1b Is the Board sufficiently aware of the potential risk to quality?	The Board regularly assesses and understands current and future risks to quality and is taking steps to address them.	NR AC SC	Board and TEG receive quarterly Top Risk Report which include high level risks to quality Board, Audit Committee and TEG receive six monthly Assurance Framework which include strategic risks to quality objectives Risks to quality are routinely considered in major Board-approved policy initiatives via project management arrangements and risks are reported to Board via project board reports e.g. Clinical Reconfiguration, Hospital at Night, Transforming Community Servces, Super decontamination, PatientCentre etc
	The Board regularly reviews quality risks in an up to date risk register.		Board access quality-related risks on the Risk Register via Top Risk Report and Assurance Framework.
	The Board's risk register is supported and fed by quality issues captured in directorate/ service risk registers.		Safety and Risk Management Board includes Service and Directorate representatives, meets monthly, agenda includes discussion regarding Occupational and Patient Safety issues and planning to address concerns. Variation in the maintenance of Directorate risk registers. Work is underway to improve and standardise usage via Safety and Risk Management Board and the Risk Validation Group. The process for escalating risks and assessing the potential for aggregation is outlined in the Risk Management Policy and Strategy which is annually approved by the Board. Risk Validation Group currently meet monthly to review all new risks to promote consistency and compliance. RVG plans to extend scope to review all existing risks (on completion of the Housekeeping Exercise – above). Part of the RVG's role is to highlight any risks (including risks that require escalation or are deserving further consideration e.g. aggregation) in a monthly paper to TEG.

QUESTIONS	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
1b cont/d Is the Board sufficiently aware of the potential risk to quality?	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.	NR AC SC	Scope of quality risks on Trust Risk Register is reasonable. Top Risk Report and Assurance Framework are more likely to consider external risks to quality rather than operational risks which are closer to current practice.
	There is clear evidence of action to mitigate risks to quality		For quality risks included in the Top Risk Report, Executive Risk Leads are required to document progress against action plans to mitigate the risk and to score the current residual risk (at the time of reporting) and demonstrate the journey from the initial risk score to a target risk score which has a documented rationale. For quality risks included in the Assurance Framework, all gaps in controls or assurances have an action plan to mitigate – routinely this is linked to the Top Risk Report. For other operational risks logged on Datix, risk owners are required to describe mitigating action plan and update progress via regular reviews signed off by directorate risk/governance meetings. This process will be monitored via the Risk Validation Group on completion of the Housekeeping Exercise.
	Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment).		Quality impact risk assessment routinely undertaken for major policy initiatives via project management arrangements and risks are reported to Board via project board reports. Examples: • Service change risk assessment guidance issued. • Business Planning Team has clinical representation to review clinical implications • P & E programme is designed to address quality as well as reducing costs. • Annual Plan – illustrates initiatives are risk assessed
	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)		Service Improvements - analysis • Various Service Improvement Projects • KM&T search process and engagement • Directorate schemes

QUESTIONS	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
1b cont/d Is the Board sufficiently aware of the potential risk to quality?	• 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)	NR AC SC	Benchmarking work • NHS Quest • Association of UK University Hospitals - Benchmark against provincial teaching hospitals • Dr Foster analysis – Alerts are addressed through the Clinical Effectiveness Committee and appropriate Clinical Director • Other areas of monitoring include Cardiac, Rheumatology and Orthopaedic
	• 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).		Service Improvement Projects e.g. • Clinical reconfiguration • Hospital @ Night • Stroke pathway and PPCI
	The Board is assured that initiatives have been assessed for quality		Stated role of Medical Director & Chief Nurse on the Board P&E plans risk assessed and reported quarterly to the Board
	All initiatives are accepted and understood by clinicians		Management Arrangements 2009 (Refresh) Clinically focussed management arrangements with 27 clinical directorates. Clinicians lead all quality initiatives.
	There is clear subsequent ownership (e.g. relevant clinical director)		Examples • Out patients • Project Evie.
	There is an appropriate mechanism in place for capturing front-line concerns, including a defined whistleblower policy		Whistle Blowing Policy in place which enables staff to raise concerns and for those concerns to be dealt with in a receptive and proactive way.
	Initiatives' impact on quality is monitored on an ongoing basis (post-implementation)		Example PIs: • Nurse Sensitive Indicators • Performance Management Framework • eCAT • Acuity & Dependency
	Key measures of quality and early warning indicators identified for each initiative		Monitored generically through – HSMR reporting, SUI reports, Nurse Sensitive Indicators

QUESTIONS	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
1b cont/d Is the Board sufficiently aware of the potential risk to quality?	Quality measures monitored before and after implementation	NR AC SC	PDSA part of Service Improvement initiatives, which enables pre and post measurement. Part of project plan e.g. Hospital @ Night
	Mitigating action taken where necessary		Part of project implementation e.g. • Stroke pathway – Strategic decision to move Stroke services to another location, Mid project based on feedback and learning throughout the project • Hospital @ Night – scaled back initial plans for to a stepped approach based on learning at the start of the project

2 CAPABILITIES & CULTURE

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
2a Does the Board have the necessary leadership, skills and knowledge to ensure deliver 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)	NR SC KM	Healthcare Governance Committee: Board committee with annual work plan, covers CQC essential standards and other compliance and quality topics. NED Chair. Audit Committee: Board committee with NED chair, regular reporting schedule including adverse internal audits. Board Development: Strategic sessions – 4 times per year Quarterly Group NED meetings with the Chair
	The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board		Board Composition: Experienced and established Board e.g. • University representative • CEO Age UK Doncaster • Member of National Quality Board Board members recruited against person spec formally reviewed when any vacancy arises to ensure the Board has a full range of skills
	Board members are able to:		
	• Describe the trust's top three quality related priorities		Currently part of the strategy – clinical outcomes and patient experience

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
2a cont/d Does the Board have the necessary leadership, skills and knowledge to ensure deliver of the Quality Agenda?	• Identify well and poor performing services in relation to quality and actions the trust is taking to address them	NR SC KM	SLR Work stream: SLR position presented by specialty at commencement of strategy refresh SUI Group: Weekly meeting including Executive Directors to discuss potential SUI's, planned action and monitor progress. Nurse Sensitive Indicators Performance Management Framework eCAT
	• Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines recognised Royal College or Faculty measures)		NICE Programme: Proactive implementation of NICE publications co-ordinated by NICE Information Co-ordinator / NICE Implementation Group & performance managed by the Clinical Effectiveness Committee via Trust Clinical Audit Programme and commissioned Clinical Effectiveness Programme. Part of QUEST and Association of UK University Hospitals benchmarking group Mortality Outliers: Proactive surveillance of hospital mortality against national benchmarks via use of Dr Foster Real Time Monitoring and structured reporting of outcomes every 2 months to Clinical Effectiveness Committee (CEC). Significant outliers formally investigated and results fed back to the Clinical Effectiveness Committee and Medical Director. Routine monitoring and reporting of HSMR to Healthcare Governance Committee each quarter & tracking of development of SHMI. Other Benchmarking: Routine benchmarking against recommendations of confidential enquiries, overseen by the Clinical Effectiveness Committee, as included in Trust Clinical Audit Programme. Increase in number of emerging national Key Indicators forming part of national audits, which are accepted as indicators of good quality care. As results of national audits are fed back locally, action plans focus on key indicators and these go the Executive Director Lead (Medical Director), the Clinical Effectiveness Committee and are incorporated into feedback to the clinical areas via clinical governance leads.
	• Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them		Healthcare Governance Committee Minutes: Evidence of discussion and clarification from minutes
	• Be clear about basic processes and structures of quality governance		Understand the twin aspects of clinical outcome & patient experience
	• Feel they have the information and confidence to challenge data		Yes – within own areas of speciality (VF response)

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
2a cont/d Does the Board have the necessary leadership, skills and knowledge to ensure deliver of the Quality Agenda?	• 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.	NR SC KM	In line with the Governance Code requirements arrangements are in place to seek external assurance.
	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)		Examples: • Moss Lane commissioned report • Patient Safety First Campaign • QUEST – CEO Leadership • Service Improvement Team – MD Leadership • TCS process – Commissioned report from Pat Cantrell
	The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained.		Board succession planning: • Appointment process for new non executive governor (Human Resources Committee lead) • Appointment process for new Chairman – has required assessment of current Board Board Development: TEG to undergo Insights Assessment – as used on the Senior Leadership Development Programme with Sheffield Hallam University (to be reviewed for the Board following appointment of new Chair) Quarterly time outs. Three yearly board development.
	Board members have attended training sessions covering the core elements of quality governance and continuous improvement.		Individual and Board Developments: • Board member attended recent in-house Service Improvement Course (July 2011), which included core quality improvement training with international, national and local examples. • Non-Executive has taken lead to coach two medical members of the SI Team. • Medical Director – Service Improvement learning (IHI Boston – 2day meeting CEO faculty, IHI/Health Foundation Clinical Fellow work stream and QUEST learning events) • Chief Nurse/Chief Operating Officer – Experiential learning member of Future Forum and National Quality Board • Regular agenda item Clinical Update promotes clinical improvement e.g. Diabetes, Hospital @ Night, enhanced recovery, patient safety. • Think Glucose work stream (NED involvement – VF)

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
2b Does the Board promote a quality focus culture throughout the Trust?	The Board takes an active leadership role on quality	MR SC	The Board agenda and visit programme ensures that Board members are actively engaged in the quality agenda across the Trust. Each month there is a clinical update, which ensures good practice, but also risks/harm are highlighted for action.
	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 encourages staff to link to other Trusts to compare and learn. For example, a recent visit to Leeds Hospitals led by one of the Associate Medical Directors (on behalf of the Medical Director) focussing on how to improve safety in the management of medicines and Addenbrooke's to review Infection Control measures.
	The Board regularly commits resources (time and money) to delivering quality initiatives		In addition to the core Quality Assurance, Patient Safety and Clinical Audit & Effectiveness resources, the Board has committed to a Clinical Service Improvement Programme since April 2010. These programmes oversee a range of cross-organisational quality improvements in addition to supporting individual clinical teams to make local improvements. There is an annual investment fund, which is used to deliver improvements – examples would include the delivery of the Hospital at Night model and introduction of 7 day working in Therapy Services.
	The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members		Clinical Service Improvement Programme is led by the Medical Director and initiatives have been directly led by him and another Executive i.e. Reconfiguration Investment Committee (NED involvement)
	The Board encourages staff empowerment on quality		
	Staff are encouraged to participate in quality/continuous improvement training and development	MR SC	Leadership Programmes: • MBA in Medical Leadership • Senior Leaders Programme
	Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment)		Incident Reporting System and Policy: This is highlighted at induction and is included in the staff survey Safety and Risk Management Board
	Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery)		Management structures: Staff are encouraged to continuously seek ways to improve quality and accountability is through the existing management structures. Service Improvement Courses: The Trust commenced a training programme this year (Sheffield Course In Patient Safety) to encourage staff to identify and resolve quality issues. The Trust also had teams on the regional TAPS program with similar aims SUI Processes: Rigorously performance managed by Executive group members

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
2b cont/d Does the Board promote a quality focus culture throughout the Trust?	Internal communications (e.g. monthly newsletter, intranet, notice boards) regularly feature articles on quality		Communications Strategy: There are a variety of internal communications – Weekly Webex (management community); intranet; staff newsletter in which clinical quality initiatives feature.

3 **PROCESSES & STRUCTURE**

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
3a Are there clear roles and accountabilities in relation to Quality Governance?	Each and every Board member understand their ultimate accountability for quality	NR SC	Board Development and Board Activities
	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)		Performance Management Framework Management Structures 2009 eCAT Nurse Sensitive Indicators
	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		Board Agenda Clinical update All SUI and Never events reported by the Medical Director Board visits to various sites
	Quality performance is discussed in more detail each month by a quality focused Board sub-committee with a stable, regularly attending membership.		Healthcare Governance Committee: Board committee with formal terms of reference, excellent attendance evidenced in annual report.

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
3b Are there clearly defined understood processes for escalating resolving issues and managing Quality Performance?	Boards are clear about the processes for escalating quality performance issues to the Board	SC VF	
	• Processes are documented		SUI Group Safety and Risk Management Board Risk Validation Group
	• There are agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints.		
	Robust action plans are put in place to address quality performance issues (e.g. including issues arising from serious untoward incidents and complaints). With actions having:		
	• Regular follow-ups at subsequent Board meetings		Management of SUIs: Documented process in place, performance managed by Executive Directors at SUI meeting.
	• Regular follow-ups at subsequent Board meetings		
	Lessons 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.		National Audit Results: Discussed at Board Level and relevant groups across Trust with impetus to change e.g. Stroke SUI Process: Lesson identified from investigations are shared at Healthcare Governance Committee and to all risk leads via SRMB (SUI Form C) CAS system in place for immediate alert e.g 'Insulin incident' Productive Series Theatre and Ward improvement projects

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
3b cont/d Are there clearly defined understood processes for escalating resolving issues and managing Quality Performance?	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. • Continuous rolling programme that measures and improves quality • Action plans completed from audit • Re-audits undertaken to assess improvement	SC VF	Trust Clinical Audit Programme (TCAP): Proactive annual prioritisation of national and local audit priorities (in line with HQIP guidance and local Clinical Audit Policy). The high priority audits are agreed with directorate governance teams and form the Trust Clinical Audit Programme together with incomplete high priority audits from the previous year. The TCAP is performance managed through the Clinical Effectiveness Committee (2 monthly) and received by Healthcare Governance Committee (annually). A subset of this is also performance managed by the PCT commissioner quarterly. Lower priority audits not included on the Trust Clinical Audit Programme (mostly generated by interested clinicians) are not formally corporately performance managed, but progress is tracked via Directorate Clinical Audit Programmes by Clinical Effectiveness Unit staff with the support of the directorate management team. These audits would normally be discussed and actioned at the local governance / audit meeting. Action plans are pursued for all NCAPOP audits, reported through to CEC and the vehicle for follow up on any areas of concern established. The TCAP also includes NICE guidance audits and other high profile national guidance audits, including National Confidential Enquiry recommendations, clinical accreditation schemes and audits resulting from SUI's. The Clinical Effectiveness Unit directs re-audit of high priority audits. For lower priority audits the decision to re-audit remains with the directorate executive management team (co-ordinated by the Directorate Audit Lead). Re-audits can be identified in the Unit database from the title & reports extracted to highlight what % projects are re-audits,
			Internal Audit Programme: Annual agreed planned process covering high-risk areas approved and performance managed by Audit Committee and is the responsibility of the Director of Finance. The internal audit plan includes a variety of areas including financial systems, governance arrangements of specific areas identified by the Trust where there are weaknesses or assurance requirements. Results are reported to the Audit Committee and provide an Annual Report at the year-end on all work undertaken in the year. Trust CQC Compliance Review Group: Regular reviews of compliance with essential standards supported by QRPs. Audits included in the QRP cover the 6 "Participation in Cardiac Audits" and are listed in the National Clinical Audit & Patient Outcomes Programme (NCAPOP) and hence the Trust Clinical Audit Programme. Other relevant QRP indicators include set up and

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
3b cont/d Are there clearly defined understood processes for escalating resolving issues and managing Quality Performance?	A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle	SC VF	Whistle Blowing Policy
	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.		Performance Management Framework Capability policies
3c Does the Board actively engage patient, 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	HAC SB SC	Patient Experience Report: Quarterly report is comprehensive and presents all feedback and patient experience performance information, good and bad. Dr Foster Good Hospital Guide: Published on line and widely reported in the media. Clinical Audit: National Clinical Audit web sites with public access and annual Public Reports of National Audits. Quality Report: Section on clinical audit reporting participation in national audit programme
	The Board actively engages patients on quality e.g.		
	• Patient feedback is actively solicited, made easy to give and based on validated tools.		Comment cards on every ward Ongoing programme of Frequent Feedback real-time surveys. Programme of national in-patient and out-patient surveys. National programme of Patients Reported Outcome Measures. Programme of local level surveys using Snap software. Website feedback can be given direct through Trust website. Other websites are actively monitored and feedback actioned, including NHS Choices, Patient Opinion and the Sheffield Forum. Website feedback is reported monthly. Over 600 members on Trust Patient and Public Involvement (PPI) database, which is used for consultations and for specific initiatives

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
3c cont/d Does the Board actively engage patient, staff and other key Stakeholders on Quality?	• Patient views are proactively sought during the design of new pathways and processes	HAC SB SC	A variety of methods are employed in engaging patients/public in design/redesign processes. Examples include patient surveys (Cystic Fibrosis Unit) and workshops (Transforming Community Services). Patient Involvement in Clinical Audit: Patient and Public Governors are members of the Trust Clinical Effectiveness Committee and can input at the strategic level. We have examples where Patient Governors / representatives also sit on NICE guidance implementation groups for specific guidance's e.g. Nutrition Steering Group or national strategy implementation groups e.g. Dementia Care Group (minutes as evidence). In this way, patients can be involved in the development of new pathways and processes.
	• All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board		Monthly complaints and feedback reports, monthly Frequent Feedback reports and quarterly patient experience reports are reviewed by the Patient Experience Committee (PEC). Quarterly complaints reports and quarterly patient experience reports are reviewed by the Healthcare Governance Committee and by the Board. Annual complaints and patient experience reports are reviewed by the Patient Experience Committee, the Healthcare Governance Committee and the Board.
	• The Board regularly reviews and interrogates complaints and serious untoward incident data.		Quarterly and annual complaints reports are reviewed by the Board
	• 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)		Board members meet personally with patients or families in relation to concerns and complaints. There is a programme of Board visits to patient areas.
	The Board actively engages staff on quality, e.g.	MG	
	• 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)		Staff are encouraged to give feedback via 'Lets talk' events/annual staff survey and in clinical areas the CAT staff survey which has a strong emphasis on quality.

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
3c cont/d Does the Board actively engage patient, staff and other key Stakeholders on Quality?	• All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board	MG	Feedback from Let's talk events included with staff survey results and fed back annually to Board.
	The Board actively engages all other key stakeholders on quality e.g.	HAC SB	
	• Quality performance is clearly communicated to commissioners to enable them to make educated decisions		The Patient Experience Committee and other groups and committees within the Trust include representation from the Local Involvement Network (LINk) There is an open invitation to Commissioners to attend the Patient Experience Committee and Commissioners receive all Committee papers and reports. Quality monitoring information is provided to Commissioners. Trust governors are key members of the Patient Experience Committee and other relevant groups and committees. As such, they are actively involved in discussing and reviewing complaints and other patient experience feedback.
	• Feedback from PALS and LINks is considered		LINk members are represented on groups and committees across the Trust. Action plans are agreed following LINk Enter and View visits. Recommendations from Enter and View visits and associated action plans are summarised in the quarterly patient experience reports. PALs feedback is included in the monthly complaints and feedback reports and the quarterly patient experience 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		Examples where this works includes; Enhanced Recovery, Stroke, Heart Failure, Diabetes, Learning Disabilities and Maternity.
	The Board is clear about Governors' involvement in quality governance.	NR	Governors involvement: • Governing Council Agenda • Quality Report production and monitoring • Clinical Effectiveness Committee • Patient Experience Committee

4 MEASUREMENT

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
4a Is appropriate quality information been analysed and challenged	The Board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include:	NR AP SC	
	• Key relevant national priority indicators and regulatory requirements		Monthly Health-check Report: Summary of key indicators and performance reported to Operational Board, TEG and the BoD
	• Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each)		Performance Management Framework Monthly Health-check Report
	• Selected 'advance warning' indicators		Dr Foster monitoring process
	• Adverse event reports/serious untoward incident reports/patterns of complaints		Complaints, Claims and Incidents Report: Quarterly summary report submitted to Healthcare Governance Committee
	• Measurers of instances of harm (e.g. Global Trigger Tool)		Global Trigger Tools: Outcomes discussed at Clinical Update session at the Board
	• Monitor's risk ratings (with risks to future scores highlighted)		Reported in the Board CEO report
	• Where possible/appropriate, percentage compliance to agreed best practice pathways		Quality Report: Stroke priority, PPCI etc.
	• Qualitative descriptions and commentary to back up quantitative information		Monthly Health-check Report
	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		

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
4a cont/d Is appropriate quality information been analysed and challenged	The Board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines	NR AP	Performance Management Framework Monthly Health-check Report
	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.		Monthly Health-check Report: Reviewed and updated in February and March 2011. Addition of CQUINs indicators and recently agreed monitoring of Quality Report priorities
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	MR SC	Routine Quality Information: Routine monitoring and reporting of HSMR to Healthcare Governance Committee takes place each quarter and development of SHMI is being actively tracked. Routine monitoring of Dr Foster Real Time Monitoring Performance Summaries by Clinical Effectiveness Committee every 2 months. Peer review against other organisations and trend analysis possible. Results of national and local clinical audit provide a regular source of information on the quality of care at the Trust and the Annual Trust Clinical Audit Report provides a resume. Analysis of national PROMs data and local patient experience data collected via Picker hand-held system & National / local Clinical Audit Surveys and reported in Patient Experience Report. Participation in National Audit Validation Studies e.g. MINAP, Congenital Heart Disease, Lung Cancer audits. Ongoing validation work for large NCAPOP data submissions e.g. Diabetes, heart disease audits.
	• Each directorate/service has a well documented, well functioning process for clinical governance that assures the Board of the quality of its data.		Healthcare Governance Framework: Framework outlines requirements for each Directorate clarifying roles and responsibilities and expectations for local Governance Arrangements

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
4b cont/d Is the Board assured of the robustness of the quality information?	• 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)	MR SC	Prioritisation of Trust Clinical Audit Programme (TCAP): Proactive annual prioritisation of national and local audit priorities (in line with HQIP guidance and local Clinical Audit Policy) – see copy of TCAP. Priority 1 audits are "external must-do's" and include NCAPOP audits, audits of NICE guidance and other high profile national audits, National Confidential Enquiry recommendations & accreditation schemes. Priority 2 audits are "internal must-do's" and result from high profile initiatives, patient safety initiatives & SUI's. Some audits of high priority to specific directorates, priority 3, are also included on the TCAP and may result from local risk issues.
	• Electronic systems are used where possible, generating reliable reports with minimal ongoing effort		Electronic systems within the Trust such as PAS, Information Service data warehouse, Infoflex etc are all capable of producing reliable reports on an ongoing basis with minimal effort. Once the reports are written and set up they can be selected and run by any user. Trust Clinical Audit Database set up to generate reports.
	• Information can be traced to source and is signed off by owners		Electronic systems have audit trails that allow the person who entered/changed the data to be identified. The original source of the data can be determined. The information governance audit that compares the data in case notes to the data on the system enables us to assure the accuracy of the data and feedback to users.
	There is clear evidence of action to resolve audit concerns		
	• Action plans are completed from audit (and subject to regular follow-up reviews)		National Audit Action Plans: The results of national audits are communicated locally, action plans are developed (focus on key indicators) and these go the Executive Director Lead (Medical Director), the Clinical Effectiveness Committee and are incorporated into feedback to the clinical areas via clinical governance leads. The TCAP has a monitoring section to keep track of change implementation from audits that have action plans. Audit Report Template has built in action plan.
	• Re-audits are undertaken to assess performance improvement		The Clinical Effectiveness Unit directs re-audit of high priority audits. For lower priority audits the decision to re-audit remains with the directorate executive management team (co-ordinated by the Directorate Audit Lead). Re-audits can be identified in the Unit database from the title & reports extracted to highlight what % projects are re-audits,
	There are no major concerns with coding accuracy performance		Two external audits of the accuracy of clinical coding are carried out each year. In addition there is an internal audit programme. Any issues highlighted by these are investigated and resolved. There are no major concerns. Should Dr Foster mortality outcomes analysis identify any possible coding inaccuracies this is escalated and action taken to rectify.

QUESTION	EXAMPLE - GOOD PRACTICE	LEAD	CURRENT POSITION
4c Is quality information used effectively?	Information in Quality Reports is displayed clearly and consistently	NR AP SB SC	External Auditors (Audit Commission) report on Quality Report gave positive feedback on the language used in the report. Similar templates used each year for consistency.
	Information is compared with target levels of performance (in conjunction with R/A/G rating), historic own performance and external benchmarks (where available and helpful)		Clinical benchmarking (Dr Foster & AUKUH) has been used for a number of years. In recent service & quality improvement work, the Trust is using time-series data to understand where variation is "common cause" or "special cause" and to track improvements.
	Information being reviewed must be the most recent available, and recent enough to be relevant		Dr Foster Real Time Monitoring enables analysis as recent as 3 months ago (from HES data). [Plus information should include enough data points to be statistically valid – without this rigour it would be easy to just compare one number against another and draw conclusions. Use of time series data is crucial in this regard.]
	'On demand' data is available for the highest priority metrics		Data available for the highest priority metrics and for all metrics that are produced by electronic systems
	Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate)		Dr Foster RTM enables patients to be identified & notes reviewed to provide assurances on quality of clinical care. Plus increased use of patient stories (anonymised) to ensure impact beyond the statistics.
	Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance.		• Reviewing the information on VTE assessments has led to an increased coverage and improved performance. • Infection control trend analysis / tracking have demonstrated reduction in MRSA levels in response to improvements. • Patient Safety First Campaign. Reduction in harm events as implementation of evidence-based care bundle has increased. • Reviewing coding of neonatal readmissions resulted in appropriate assignation of coding to babies accompanying mums into hospital. • Numerous examples – include redesign of the way unscheduled medical patients are managed within the hospital; enhanced recovery within surgical specialities; improved management of the deteriorating patient (Hospital at Night).