St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD: MAY 2014

Paper Title:	**Quality Governance Memorandum**
Sponsoring Director:	**Peter Jenkinson** Director of Corporate Affairs
Purpose:	To provide the Trust Board and Monitor with assurance around the Trust's Quality Governance Framework
Action required by the board:	Approval of memorandum prior to submission to Monitor
Document previously considered by:	Executive Management Committee and the Quality and Risk Committee

Executive summary

As an integral part of its preparation for Foundation Trust application, the Trust has undertaken a self-assessment of Quality Governance. The output of this is the Trust Board Quality Governance memorandum. The submission of the Quality Governance Memorandum is a requirement of Monitor in order to initiate their formal assessment. The authorisation criterion is a score of 3.5 or less with no single domain being entirely red rated.

The self-assessment has been undertaken through April and May 2014, resulting in the attached memorandum. The Trust previously completed this assessment in November 2012, which was independently validated by Deloitte. Following the 2012 review an action plan to address identified gaps was completed and a further review was undertaken by Deloitte in April 2013 at which time a score of 3.5 was indicated. Since then the Trust has completed a number of actions in response to the findings of this review, with progress monitored monthly by the FT Programme Board. Actions taken over this period include:

- Embedding the Listening into Action staff engagement programme
- Embedding the quality inspections as a 'business as usual' part of the trust's quality governance framework
- Regular deep dives into quality issues in the Quality and Risk Committee seminars
- Regular reporting on the implementation of the trust quality improvement strategy
- Implementation of divisional quality improvement strategies and regular reporting on the delivery of these strategies at Quality and Risk Committees
- Development and implementation of a data quality policy and strategy

This self-assessment has also been informed by the findings of the recent Care Quality Commission inspection.

At present, this self-assessment has determined that the Trust scores 2.5.

Recommendation

The Board is asked to:

- Review and approve the attached Quality Governance Memorandum

Risks

The most significant risks on the Board Assurance Framework are detailed in the report

Quality Governance Memorandum

1. Introduction

Monitor defines 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

Monitor's guidance sets out the requirement that the Board of Directors of an applicant trust confirms through a board statement and board memorandum that it is satisfied that:

- The Trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients and
- Due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans).

2. Process of self-assessment

In preparation for Foundation Trust application the Trust has completed a self-assessment of Quality Governance led by the Director of Corporate Affairs. The outcome of this self-assessment is measured against the four categories and ten key questions as set by Monitor, using Monitor's scoring system these are detailed in Table 1.

The self-assessment undertaken throughout April and May 2014 in order to formulate the Quality Governance Memorandum was informed by the previous self-assessment undertaken by the Trust and the subsequent independent review by Deloitte in December 2012. Following the 2012 review an action plan to address identified gaps was completed and a refresh was undertaken by Deloitte in April 2013 at which time a score of 3.5 was indicated. The authorisation criterion is a score of 3.5 or less with no single domain being entirely red rated. The scoring system is detailed in Table 2.

At present, this self-assessment has determined that the Trust scores 2.5.

Collation of a significant range of evidence to support the memorandum been completed and will be provided to Monitor in conjunction with the Memorandum.

Table 2: Ten key questions

Strategy	Capabilities and culture	Processes and structures	Measurement
1A -Does quality drive the Trusts strategy?	2A -Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	3A - Are there clear roles and responsibilities in relation to quality governance?	4A - Is appropriate quality information being analysed and challenged?
1B - Is the Board sufficiently aware of the potential risks to quality?	2B - Does the Board promote a quality focused culture throughout the Trust?	3B - Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	4B - Is the Board assured of the robustness of quality information?
		3C - Does the Board actively engage patients, staff and other key stakeholders on Quality?	4C - Is quality information being used effectively?

Table 2: Scoring matrix

Risk rating	Scoring	Definition	Evidence
Green 	0.0	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber/Green 	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and robust action plans to address perceived shortfalls with proven track record of delivery
Amber/Red 	1.0	Partially meets expectations but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development with limited evidence of track record of delivery
Red 	4.0	Does not meet expectations	Major omission in Quality Governance identified. Significant volume of action plans required and concerns on management capacity to deliver

3. Memorandum

			Headlines	Score April 2013	Score April 2014
Strategy	1A	**Does quality drive the trust's strategy?**	Quality is at the heart of the Trust's strategy with the aim; 'to provide outstanding quality of care'. The Trust's Quality Improvement Strategy was originally approved by the board in November 2010 and is refreshed annually. The Strategy outlines the trust's vision for quality improvement over the next five years, detailing key priority areas and planned action to promote continuous improvement in the safety and quality of services provided by the trust. This strategy is updated annually and implementation is monitored quarterly by the Quality and Risk Committee, the board sub-committee with over-arching responsibility for quality. Each division has a quality improvement strategy which is aligned to the overarching trust strategy and implementation of these is also monitored by the Quality and Risk Committee bi-annually. Aligned to its strategic goals, the board has agreed five year strategic objectives and annual objectives to monitor delivery of the trust's strategy. The board receives quarterly performance reports against the annual objectives. The trust has invested over £2m in the development of a Trust Improvement Programme (TIP). All TIP projects are aligned to improve patient flow which directly impact on patient experience and safety – 'right patient, right place, right time'. Areas for improvement: - Implementation of the recommendations from the ward establishment review – June onwards	0.5	0.5
	1B	**Is the Board sufficiently aware of potential risks to quality?**	The trust has a risk management framework to ensure management of risk across the organisation. The core of this framework includes the Quality and Risk Committee (QRC) and the Executive Management Team. The three main sub-committees of QRC are the Patient Safety Committee (PSC) and Patient Experience Committee (PEC) chaired by the Chief Nurse and the Organisational Risk Committee (ORC), chaired by the Director of Corporate Affairs. There is a clear process of risk identification, evaluation, monitoring and reporting from divisions, through corporate committees and ultimately by the Board. Each division and each corporate directorate maintains a risk register and there is a Board Assurance Framework (BAF) which acts as the corporate risk register. Each risk captured on the Board Assurance Framework (BAF) is aligned to the trust objectives. A full overview of the BAF is undertaken by the Executive Management Team and it is reviewed at the QRC ahead	0	0.5

			of being reported to the Board as part of the Risk and Compliance Report to every Board meeting. In addition, the highest rated Divisional risks are included as part of the BAF review and reporting process as the BAF and a detailed review of Divisional Risk Registers is undertaken at the ORC. External scrutiny of the highest clinical risks to quality has also recently commenced by commissioners as part of regular reporting to the monthly Clinical Quality Review Group (CQRG) meeting. The CQRG also identifies clinical risk through scrutiny of serious incidents and examples of improvements to quality and safety can be evidenced by decisions made at this forum There is a Clinical Governance Group (CGG), responsible for scrutinising the quality impact assessment of all highest risk rated CIP schemes (12 or above) with Divisional accountability for monitoring local schemes and for escalation of those schemes deemed to be of higher risk. The processes in place to monitor the impact of CIP schemes on quality have been subject to a robust review by the NTDA and commissioners. The CGG reports to the QRC and in turn any concerns identified at QRC would be escalated to Board level. **Areas for improvement:** - CQC identified the need to improve Divisional Risk Registers - Implementation of the actions from the divisional governance review to strengthen current arrangements - Ensure that run rate Cost Improvement (CIP) schemes have a quality impact assessment - The Trust should continue to develop the integrated view of performance for Board to include a summary of quarterly performance reviews across all performance domains		
Capabilities and culture	2A	**Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?**	The Trust Board comprises 16 members: Chairman, five non-executive directors, four executive directors, five non-voting executive directors and an associate non-executive director. Amongst the board members there is one nurse, and four medically qualified doctors: Medical Director, Principal of St. George's University (NED), Medical Doctor (NED) and a Consultant in Public Health (the Director of Strategic Development). The composition and skills of the Board are regularly assessed which then informs succession planning. A skills audit of the Board has been carried out within the last 12 months and effectiveness of board sub-committees is assessed on an annual basis. There have been changes to the board committee structure, including the Quality and Risk Committee, and the recruitment of a non-executive director with a clinical / quality background as a result of this review.	0.5	0

			In order to ensure board level knowledge of quality, the trust has introduced quality and risk seminars every two months to which all board members are invited, and a board development programme has been undertaken which includes topics such as quality and risk management. The four clinical divisions are led by a Divisional senior management team which comprises a Divisional Chair (all medical doctors) a Divisional Director of Nursing and Governance (nurse) and a Director of Operations. A recent review of governance structures and processes at Divisional level has been carried out to ensure governance arrangements within divisions have quality at the centre of its business. In 2013, the Chief of Therapy post was also established to strengthen leadership of these professional groups. The membership of QRC, the board sub-committee responsible for quality, comprises three non-executive directors, of whom two are clinical, and four executive directors including the Chief Nurse and Medical Director. The most recent CQC report rated the trust as 'Good' in the well-led domain, highlighting the visibility of the Chief executive in all parts of the Trust. All board members take part in quality inspections and non-executive directors regularly visit different parts of the trust.		
	2B	**Does the board promote a quality focussed culture throughout the trust?**	A central function of the Trust Board is to promote a quality-focused culture across the Trust. This is achieved through the implementation of an effective reporting process that engages the Board in understanding and improving the quality of care offered by the Trust, and ensures that quality remains at the forefront of the Board's agenda and is embedded in the organisation's operations. Staff are encouraged to identify concerns and report these via the Datix-web on line reporting system. The trust has a high rate of incident reporting which can be viewed as being indicative of a positive safety culture. The recent CQC report following inspection in February 2014 noted an 'evident culture of reporting and learning from medical incidents' and commended the 'development of DVDs to engage clinical and managerial staff in reflecting on and improving practice and therefore patients' experiences'. The CQC also found that staff felt proud to work in the Trust and felt engaged and enabled to raise concerns. Executive directors and nonexecutive directors take part in a rolling programme of quality focussed inspections across the trust which offer the opportunity to engage directly with front line staff around quality issues and to hear direct staff feedback. Patient Safety weeks held across the Trust encompasses a series of conversations with staff, aligned to the Listening into Action programme of engagement with staff to hear staff concerns. An expansion of Staff	0.5	0

			safety fora are in development for student nurses and medical students. The most recent CQC report following inspection in February 2014 commended the Trust for the level of staff engagement in the quality agenda commenting that staff were proud to work here which is demonstrative of a quality focussed culture. Areas for improvement: - Continue to improve non-medical appraisal rates and medical revalidation rates		
Structures and Processes	3A	**Are there clear roles and responsibilities in relation to Quality Governance?**	Responsibilities for quality are shared across the Director of Corporate Affairs, the Chief Nurse and the Medical Director: - The Chief Nurse is responsible for Patient Safety and Patient Experience; - The Medical Director is responsible for Patient Outcomes; - The Director of Corporate Affairs is responsible for ensuring that there is a robust governance system in place to support the delivery of quality across these three domains. **Domains of quality**: **Patient Safety** (Chief Nurse); **Patient Experience (Chief Nurse)**; **Patient Outcomes** (Medical Director) **Supported by**: **Quality Governance** (Director of Corporate Affairs) The Trust's Governance Framework sets out the Trust's system of integrated governance and the mechanism by which it leads, directs and controls its functions in order to achieve its organisational objectives. The Governance Framework forms part of the overarching Governance Manual – a set of documents which set out the Trust's committee and Divisional management structures and the roles and responsibilities. The Quality and Risk Committee (board sub-committee with over-arching responsibility for quality) is chaired by a Non-Executive director with two other (clinical) Non-Executive directors as members. Three Executive Director chaired committees report to QRC: The Patient Safety Committee, Patient Experience Committee and the Organisational Risk Committee. Each has clear terms of reference and is subject to an	0	0

			annual effectiveness review. (See appendix 1 for committee structure). The CQC report noted there to be 'good governance arrangements centrally, which were, in the main implemented locally as well'. The output of the recent divisional governance review provided an assurance to the board that the current divisional governance structures are sound. Further improvements to the Divisional Governance Boards were identified to be taken forward.		
	3B	**Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?**	Quarterly divisional performance meetings are embedded as part of the Performance Management Framework and within the framework there are clear documented processes for escalation where performance issues are identified. The Divisional Governance Board identifies and deals with issues relating to quality at a divisional and service level and reports or escalates where appropriate to each respective QRC subcommittee (PEC, PSC or ORC), and through to QRC, which will request action and seek assurance on behalf of the Board. Where risks to quality are identified through other board sub-committees these are escalated appropriately – a recent example being concerns relating to RTT performance escalated by the Finance and Performance Committee to the QRC and the issue of decontamination of nasendoscopes raised through the Executive Management Team. There is a clinical audit strategy which ensures services deliver on planned clinical audits and the internal audit programme is linked to the quality governance agenda in order to provide comprehensive board assurance.	0.5	0
	3C	**Does the board actively engage patients, staff and other key stakeholders on quality?**	The Trust has a Communications and Engagement Strategy and implementation plan, approved by the Trust Board in March 2014, which provides the framework for engagement in relation to quality. The Trust has a patient reference group, a consultative group including a number of patient representatives which allows the trust to hear feedback on the quality of its services and to consult with service users on proposed service developments. The trust also includes a number of patient representatives on key quality committees within the Trust, including the Patient Experience and Patient Safety Committees. These representatives are encouraged to participate fully in meetings and have been actively involved in the development of other quality initiatives such as increasing the levels of patient feedback.	0	0

			Patient representatives also take part in the Trust rolling programme of quality inspections and have actively helped develop the programme. Other volunteers support the collection of Friends and Family Test data in Emergency Department and also undertake privacy and dignity visits. Volunteers are also involved in other Trust wide audits. The Trust also has a patient ambassador as an integral part of the Quality Improvement Strategy, whose role is to ensure adequate patient involvement in improvement projects. The Trust regularly engages with key external stakeholders both via formal meetings such as the Clinical Quality Review meeting and Health Overview and Scrutiny Panels as well as with local Healthwatch groups whose members comprise a significant cohort of the patient representative groups involved in Trust projects. There are a number of initiatives to ensure staff are engaged and involved in quality these include: - CEO open forums and briefings - Listening into Action programme - Patient Safety Events/ Forums and Patient Safety focussed weeks which include the 'Big Conversation'. Recent Executive Director led staff briefing sessions around the new of the new CQC inspection regime and the five domains of quality of services saw approximately 2000 staff attend.		
Measurement	4A	**Is appropriate quality information being utilised and challenged?**	The Trust Board receives and considers a comprehensive suite of performance reports at each meeting which includes the Quality, Risk and Compliance, Finance, Performance and Workforce reports. Each report contains a range of quantitative and qualitative indicators of quality, at divisional and corporate level. The Board reviews monthly KPIs which address the Trust's quality goals. These include: • Effectiveness and Outcomes: HSMR and SHMI, Length of Stay • Safety: falls, pressure ulcers, serious incidents, never events, infection control • Complaint trends and rates • CQC Intelligent Monitoring report • Board Assurance Framework • Compliance with external regulation and quality standards	0.5	0.5

			The Divisional quarterly performance reviews encompass the quality KPIs The frequency of the Quality and Risk Committee has been increased to monthly to allow for a deep dive into specific quality issues identified through risk management processes and /or arising out of performance reviews. The QRC has also overseen a pilot looking at thematic reviews across a number of areas of quality performance, and whether this information could be used by the Clinical Divisions to supplement their existing reports and intelligence. Areas for improvement: - Achieving and maintaining compliance with national and London quality standards		
	4B	**Is the board assured of the robustness of the quality information?**	The trust has a Data Quality Policy and Strategy. This is overseen by the Data Quality Group which reports to the Finance, Performance and Information Committee. (The Data Quality Group includes clinical staff.) There has been demonstrable progress in implementing the The Trust Mortality Monitoring Group meets monthly is chaired by an Associate Medical Director and utilises mortality data and internal benchmarking and triangulated data for example from Incidents and complaints, to identify and act upon issues of concern. A recent example of this internal alert mechanism was the early identification of an issue relating to coding in relation to cardiac patients. This issue became a subsequent CQC mortality outlier alert but was identified early internally by the Trust and prompt appropriate action taken prior to receiving an external alert. Actions identified through Clinical Audits are referred and reviewed by the Clinical Audit and Effectiveness Committee and where appropriate escalated to the Trust Audit Committee. In 2013 a Datix User Group was established to inform and oversee a number of work streams, the overarching purpose of which is to ensure the timeliness and quality of data captured through incidents reporting. The annual internal audit plan, signed off by the Audit Committee and Board, includes a range of audits which provide assurance on the quality of data being reported. **Areas for improvement:** - Development of an Information Strategy to include systematic use of benchmarking (this will also include the development of the quality intelligence function) – June 2014 - Implementation of the quality intelligence function – June 2014	1.0	0.5

	4C	**Is quality information being used effectively?**	The trust publishes its Quality Account annually and makes this readily available through its website. The production of the Quality Account is led by an executive director and is approved by the Audit Committee and Board, and clearly sets out information about the trust that is accurate, clear and reflects the position of the trust and is externally audited. Where appropriate, information is compared to historical data to provide comparisons and benchmarked against other similar Trusts. The information reflects as up to date as possible to be relevant to informed discussions and planning. All essential data about metrics is readily available on demand. Many examples of changes in practice to improve quality and safety can be provided to demonstrate that the Trust uses information effectively. The Patient Safety First group and aligned steering groups such as Falls Committee, patient ID Working Group and the Pressure Ulcer Strategy Group utilise internally benchmarked data to drive improvement projects and to inform Patient safety weeks. The trust uses a range of quality indicators and information, from various sources, to improve quality through learning. Sources of information include: SIs, complaints and patient stories, mortality data through the mortality monitoring group, Global trigger tool, FFT. The trust also uses quality inspections and quarterly compliance statements through divisional processes to identify risks and address quality issues. **Areas for improvement:** - Continue to develop the integrated view of performance for Board to include a summary of quarterly performance reviews across all performance domains - Implement the next phase of the quality inspections – including feedback / reporting mechanism to board and public – July 2014 -	0	0.5
			OVERALL SCORE	3.5	2.5