AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 24 MARCH 2011

Title:	**QUALITY GOVERNANCE REPORT**
Responsible Director:	Director of Corporate Affairs
Contact:	Bob Hibberd, Head of Governance Amy West, Clinical Governance Facilitator

Purpose:	To update the Board of Directors on the development of the Trust's quality governance framework and assurance against the associated regulatory requirements.
Confidentiality Level & Reason:	N/A
Medium Term Plan Ref:	
Key Issues Summary:	
Recommendations:	The Board of Directors is requested to: **Accept** the report on the development of the Trust's quality governance framework.

Signed:	**Date:** 24 March 2011

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 24 MARCH 2011

QUALITY GOVERNANCE REPORT

PRESENTED BY THE DIRECTOR OF CORPORATE AFFAIRS

1. **Purpose**

This paper presents an overview of aspects of the Trust's quality governance framework in development; and assurance and monitoring processes in place against the regulatory requirements of Monitor and the Care Quality Commission (CQC).

2. **Overview**

The Clinical Governance team is working to set out a clear framework for the Trust's governance of the quality and safety of services, and to establish processes for monitoring the functioning of this framework. The intention is that compliance with the CQC's Essential Standards, and other national requirements, will be a natural by-product of the effective operation of the governance framework. The Clinical Governance team is also undertaking activities to assess and monitor compliance as an interim measure to provide assurance that the Trust is meeting the standards. At the same time, the Clinical Governance team have worked with Planning and Performance and the Head of Quality Development to review the recommendations in Monitor's Quality Governance Framework and identify areas for further development in the Trust.

3. **Governance framework development**

In FY2011/12, it is intended to align Essential Standards to the Trust's governance framework. The approach is that compliance with the Essential Standards, and other regulatory requirements, is a natural by-product of the effective operation of the governance framework.

A review of committees and groups with responsibility for oversight of particular areas of governance has been commenced. The Clinical Governance team will work with the leads for these groups to clearly define their outputs, review how the groups link to national standards of quality and safety and support the leads in setting up evidence and information on Performance Accelerator that demonstrates the effective functioning of the groups.

A regular review process will be established whereby the groups review and sign off their effectiveness and the achievement of their duties/outputs.

An online Governance Framework monitoring tool is under development on Performance Accelerator which aims to record and monitor the effectiveness of key Trust committees and groups.

4. Monitoring and assuring compliance against CQC Essential Standards

A procedure has been approved by the Director of Corporate Affairs, which sets out the mechanisms for reviewing and monitoring the CQC's Essential Standards at UHB; and for providing assurance of compliance or reporting non-compliance when required to the Board of Directors. The document includes the current process which consists of three distinct aspects:

a) Review and sign-off of position statements against the standards by manager leads. This process was undertaken during January 2011 – no moderate or major concerns were raised about compliance. As part of the position statement exercise, the Clinical Governance team have compiled information and evidence for each standard using the CQC's Provider Compliance Assessments (PCAs). Any material gaps in evidence will be escalated to the relevant Director. The Planning and Performance team compile a monthly performance report for the Board, including compliance against CQC standards. The Clinical Governance team liaise with Planning and Performance to either confirm that no areas of concern have been identified against the standards, or, in conjunction with the relevant lead Director, will ensure a report is made on any non-compliance against the standards. The Director of Corporate Affairs' Governance Group will provide assurance on the monitoring process by reviewing a sample of the standards and reporting to Audit Committee. Where any major concerns about compliance are identified, this will be reported to the Board of Directors as part of the Planning and Performance report.

b) Processes are in place for reviewing the quality and safety of care at UHB, which have been identified as providing additional assurance against the Essential Standards. These include mechanisms such as the Annual Plan Risk Register; and the role of committees and groups such as the Medical Director's Clinical Quality Monitoring Group, and Chief Nurse's Care Quality Group. The 'Procedure for Monitoring and Assuring Compliance against the Care Quality Commission (CQC) Essential Standards' clearly sets out these processes and includes a diagram of the committee reporting structure illustrating the links to the Board, attached at Appendix A.

c) Review of the CQC's Quality and Risk Profile (QRP) for UHB, which is updated monthly. On the Trust's QRPs published from September 2010 to February 2011, no individual standards, or 'outcomes' have been rated as having a high risk overall of non-compliance. The QRP displays data mapped to the Essential Standards, which is used to calculate an estimate of the risk of non-compliance with each outcome. The QRP includes information from a wide range of data sources, for example national patient and staff surveys, performance against

national targets and HES data. Individual data items are scored in comparison with 'expected' performance, and are weighted according to: how closely they relate to the outcome(s) to which they have been mapped; the degree to which an item impacts on, or reflects the experiences of patients; and the CQC's level of confidence in the quality of the data. The CQC uses this information to support their monitoring of compliance with the essential standards. The Clinical Governance team review the QRP each month and ensure that any items rated negatively are reviewed and checked for accuracy by appropriate departments, such as Informatics and Planning and Performance. Where action plans are already in place for improvement, the details of these are logged for reference (for example the staff survey action plan is referenced against any negative items relating to the results of the survey). If no action plans are in place but there is an item of concern, this will be taken to an appropriate manager and Director for agreement of action. In the event that a standard is rated as high risk overall, the Director lead(s) for the standard concerned will be informed and will be provided with a report on all red and amber rated data items mapped against the standard. The Director will then either provide additional assurance to counter the QRP findings, or develop an action plan to address identified shortcomings.

Where the CQC contacts the Trust with any concerns, the Clinical Governance team will ensure a response is compiled and approved by the Director of Corporate Affairs and any other relevant Director leads before being submitted to the CQC.

5. Monitor's Quality Governance Framework

In February 2010 Monitor commenced a consultation exercise regarding a 'quality governance framework' for Boards of Trusts applying for Foundation status. The framework was designed following failings at Mid Staffordshire FT as 'a tool to encourage and support current good practice for quality governance' (Monitor, 2010).

Monitor's Compliance Framework for the current year requires that a foundation trust's annual Statement on Internal Control should include a specific comment on arrangements for quality governance. In its (separate) consultation on its Compliance Framework for 2011/12 (to which the Trust responded), Monitor has further proposed that Boards will be required to self certify that they have regard to this Quality Governance Framework, as follows:

"The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitors' 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."

Led by the Director of Corporate Affairs, a gap analysis was conducted by CG, Planning and Performance and the Head of Quality Development against the guidance in the framework. The overall assessment of the group was that UHB meets the requirements of the framework, with some areas identified for consideration in current and future developments – those points relevant to the Board are illustrated in table 1 below.

Table 1. Actions being undertaken and points for development in response to Monitor's Quality Governance Framework examples of good practice.

Element of Monitor Quality Governance Framework	**Action being undertaken and points for development**
1b: Is the Board sufficiently aware of potential risks to quality?	The Board Assurance Framework will be submitted to the BoD in April 2011 for approval. The Audit Committee will give quarterly assurance of the risk management process.
	Head of Planning and Performance is working with stakeholders to review business case guidance and will ensure a quality impact assessment is a mandatory item. Assessment process for service changes not requiring business case to be considered.
2b. Does the Board promote a quality-focused culture throughout the Trust?	Trust quality priorities to be widely communicated to staff - e.g. via quality / governance newsletter.
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	Plan to trial use of Datix for monitoring action completion from incidents and complaints.
	To consider reporting on action completion rates for SIRIs and complaints at Board, as well as at Divisional Clinical Quality Groups.
	Governance and risk presentation at corporate induction to include information about whistleblowing policy.
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	To consider development of local, regular staff surveys or feedback mechanisms.

The full gap analysis is shown in Appendix 1.

6. Recommendation

The Board of Directors is requested to **accept** this report on the development of the Trust's quality governance framework.

David Burbridge
Director of Corporate Affairs

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
1. Strategy			
1a: Does quality drive the Trust's strategy?	▪ Quality is embedded in the Trust's overall strategy 1. 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 2. Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff 3. Quality goals are selected to have the highest possible impact across the overall Trust 4. Wherever possible, quality goals are specific, measurable and time-bound 5. Overall Trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service) 6. There is a clear action plan for achieving the quality goals, with designated lead and timeframes	Met	1. The Trust 5 year strategy has a core purpose for Clinical Quality and another for Patient Experience. Underpinning these are 32 key tasks against which progress is reported to BoD every quarter. 2. There are quality goals that incorporate national requirements and locally identified measures. 3. The majority of measures are specific, measurable, and time-bound. Some of the local specialty indicators do not have goals identified but this is being addressed at present by the Head of Quality Development. 4. A bottom-up approach was taken to the development of the Trust Strategy and each clinical and corporate service has been included. 5. The annual plan serves as the document that supports delivery of the Trust strategy. Each key task has an identified Executive Lead and timescale for delivery. The template annual plan for 2011/12 is being further refined so that each key task has identified outcome measures to provide additional assurance of delivery. 6. CQUINs and Quality Accounts include the organisation's priorities for quality and delivery of these are part of the Trust strategy and annual plan
	▪ Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the Trust and the community it serves	Met	Quality webpage has been developed. Quality goals are understood at a senior level, need to be communicated across the organisation. Trust vision and values communicated widely via new appraisal process.
	▪ The Board regularly tracks performance relative to quality goals	Met	The monthly BoD performance reports contains a section on outcomes. The BoD also receives quarterly updates on progress with delivering the Trust's quality priorities.
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	Met	The Board Assurance Framework will be submitted to the BoD in April 2011 for approval. The Audit Committee will give quarterly assurance of the risk management process.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
	▪ The Board regularly reviews quality risks in an up-to-date risk register	Met	As above.
	▪ The Board risk register is supported and fed by quality issues captured in directorate/service risk registers	Met	Serious risks from Divisional Risk Registers are included on the Board Assurance Framework which is monitored by the Audit Committee.
	▪ 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	Met	Revised Board Assurance Framework will cover these elements.
	▪ There is clear evidence of action to mitigate risks to quality	Met	Serious risks from Divisional Risk Registers are included on the Board Assurance Framework which is monitored by the Audit Committee.
	▪ Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment)	Met	Business cases are requried to provide information on how the proposed development will impact on quality and the patient experience. There is also a section on anticipated outcomes so there is a clear framework for measuring the successful delivery post-implementation.
	▪ 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 changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints)	Met	As above.
	▪ The Board is assured that initiatives have been assessed for quality	Met	As above.
	▪ All initiatives are accepted and understood by clinicians	Met	Not all initiatives will be accepted by all clinicians - the emphasis should be on clear communication with and involvement of clinicians by Divisional management teams, as part of a process of assessing impact on quality.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
	▪ There is clear subsequent ownership (e.g. relevant clinical director)	Met	As above for other initiatives. Accountability at Exec level depending on type of business case (e.g. consultant post would rest with Medical Director). Ownership at a Divisional level rests with Divisional Director or Director of Operations (again depending on nature of business case).
	▪ There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistleblower policy	Met	Whistleblowing policy in place.
	▪ Initiatives' impact on quality is monitored on an ongoing basis (post-implementation)	Met	Business case outcomes assessment process in place which is reported to BoD on a 6-monthly basis which reports on financial and non-financial outcome delivery. Exception reports contain mitigating actions/exit strategy where required.
	▪ Key measures of quality and early warning indicators identified for each initiative	Met	As above.
	▪ Quality measures monitored before and after implementation	Met	As above.
	▪ Mitigating action taken where necessary	Met	As above.
2. Capabilities and culture			
2a. Does the Board have the necessary leadership and skills and	▪ 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)	Met	NED appraisals, attendance records, Board self-assessment, annual plan governors' reference group, Executive Appointments and Remuneration Committee (EARC) review of composition of board - experience and skills mix.
	▪ The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board	Met	EARC review of composition of board re experience and skills mix

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
	▪ 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.	Met	Andrew Corbett-Nolan extrernal assessment included interview of NEDS etc. As above re appraisal and assessment.
	▪ 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)	Met	
	▪ The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained	Met	As above re appraisal and assessment.
	▪ Board members have attended training sessions covering the core elements of quality governance and continuous improvement	Met	Monitor programme
2b. Does the Board promote a quality-focused culture throughout the Trust?	▪ The Board takes an active leadership role on quality	Met	Trust-wide quality priorities are identified annually and reported through the quality accounts. Executive Governance visits undertaken by Board members.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
	▪ The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations)	Met	Analysis has been conducted against the recommendations of inquiries - e.g. Mid Staffs. Further review of recommendations is facilitated by the Clinical Governance team.
	▪ The Board regularly commits resources (time and money) to delivering quality initiatives	Met	Business cases.
	▪ The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members)	Met	Evidence includes 5 quality improvement priorities in the Quality Account, Executive Root Cause Analysis meetings, Matching Michigan project for example.
	▪ The Board encourages staff empowerment on quality	Met	Divisional clinical and management attendance at Executive root cause analysis meetings. Whistleblowing policy and Chief Executive's Hotline provide additional routes for reporting quality issues.
	▪ Staff are encouraged to participate in quality / continuous improvement training and development	Met	Staff are encouraged through Best in Care workshops, Clinical Audit Workshops and specific clinical audit training for junior doctors for example, though there is no training specifically called quality or continuous improvement training.
	▪ Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment)	Met	Incident reporting has increased over the last year. Training on risk management and incident reporting (including at corporate and junior doctor induction) emphasises learning from incidents and the Being Open policy.
	▪ Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery)	Met	The new appraisal process enables staff to record examples of where they have delivered against the Trust's values including innovation which covers quality initiatives to improve services. Performance Review, monthly performance reports, business case outcomes reports, quality accounts, CQUINs. Staff are responsible for producing action plans in response to findings of clinical audits and recommendations from complaint and serious incident (SIRI) investigations. Annual Plan quality section.
	▪ Internal communications (e.g. monthly news letter, intranet, notice boards) regularly feature articles on quality	Met	Articles on intranet, 'In the Loop' and 'Inside Out' frequently relate to quality. Team Brief quality updates by Executive Medical Director. Trust Vision and Values communicated to staff at induction and part of appraisal.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
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	Met	
	▪ 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)	Met	Medical Director and Chief Nurse have Director level responsibility for quality of care. Management structures in place at Divisional and specialty level. Processes in place to hold staff acountable for quality, e.g. RCAs. All staff responsible for meeting the Trust's Vision and Values, which are part of new appraisal process.
	▪ 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	Met	
	▪ Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership	Met	CQMG, Care Quality Group, and new Patient Safety Group which reports to CQMG.
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	▪ Boards are clear about the processes for escalating quality performance issues to the Board - Processes are documented - There are agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints.	Met	Structured monitoring and escalation process for external targets and internal indicators. Methodology documented on an annual basis in KPI update paper.
	▪ Robust action plans are put in place to address quality performance issues (eg, including issues arising from serious untoward incidents and complaints). With actions having: - Designated owners and time frames - Regular follow-ups at subsequent Board meetings	Met	Action plans in place and shared at high level in Board KPI papers for some performance issues. SIRIs are monitored at CQMG, complaints at Care Quality Group.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
	▪ 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	Met	RCA process, action plans from SIRI investigations and complaints.
	▪ 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	Met	Clinical audit team request audit reports and action plans and track actions from recommendations of national audits.
	▪ A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle	Met	Policy in place and has been used. Junior doctor induction includes information about whistleblowing.
	▪ 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	Met	Regular structured performance reviews for performance at divisional and service line level. Clear appraisal policy and procedure for individual performance with ~85% of staff appraised in last 12 months.
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	▪ Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance	Met	1. Annual Quality Reports and quarterly progress updates for quarters 1,2 & 3 each year (Q4 subsumed into annual report). 2. Quality webpages with increasing indicators but also to include Trust-level patient experience data from March 2011. 3. 2011-12 Annual Plan features objective around improving accessibility of such info. 4. Informatics reviewing NHS Outcomes Framework - whole NHS level outcome measures lend themselves to HED tool. 5. Consideration needs to be given to publishing performance against those NICE Quality Standards (as GPs and patients may start asking about them) we can measure.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
	▪ 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 an ongoing basis, with summary reports reviewed regularly and intelligently by the Board - The Board regularly reviews and interrogates complaints and serious untoward incident 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)	Met	Patient feedback via bedside survey and reported via clinical dashboard - also reported at Care Quality Group and Patient Experience Group. Executive governance visits include discussion with patients.
	▪ 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	Partly met	Action plan developed by HR following publication of annual staff survey results. Staff feedback is sought and acted upon during executive governance visits.
	▪ The Board actively engages all other key stakeholders on quality, e.g.: 1. Quality performance is clearly communicated to commissioners to enable them to make educated decisions 2. Feedback from PALS and LINks is considered 3. 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 4. The Board is clear about Governors' involvement in quality governance	Met	1. Quality Performance Report, Risk Management/ Governance & Quality Account update reports shared with PCT at monthly contract meetings. 2. PALS reports via Care Quality Group 3. Primary Secondary Care Interface meetings held with GP and commissioner representatives - review pathways. Director of Partnerships in place to engage with key stakeholders. 4. Joint BoD / BoG seminars on quality.
4. Measurement			

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
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/ serious untoward incident reports/ patterns of complaints - 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	Met	The BoD monthly performance reports include the CQC and Monitor regulatory requirements (including risks to future scores). Indicators are grouped into specific sections, these include Safety, Patient Experience, and Outcomes. The indicators are due for annual review for March BoD. Further work may be required to ensure Effectiveness is adequately addressed. In relation to early warning indicators, historic performance is assessed and each measure has traffic light thresholds so there are clear parameters and triggers when performance deviates from acceptable levels. In addition, annual Quality Report and quarterly progress update reports to the BoD contain key metrics and indicators covering safety, effectiveness and patient experience.
	▪ 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	Met	Metrics are reviewed on at least an annual basis to ensure they are still useful and reflect the Trust's core purposes and the annual plan. If priorities change in year then these will be reflected in the performance reports. Quality improvement priorities and content of Quality Report subject to annual review by CQMG, Care Quality Group, BoD, BoG, PCT & LINk.
	▪ The Board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines	Met	Board level performance reports are at organisational level. Chief Operating Officers Group divisional clinical and management leads reviews performance at divisional level for all indicators and service line for exceptions. role based dashboards are in development to support performance and operational delivery.
	▪ Quality information is analysed and challenged at the individual consultant level	Met	Consultant level detail is analysed for selected clinical quality metrics at CQMG and exceptions are followed up. Consultant performance is reviewed at appraisal.
	▪ 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	Met	Metrics undergo formal review annually and in year changes are made as required to reflect organisational risks/priorities. Further work is required to ensure progress is made in developing 'new' indicators.

Quality Governance Framework	Example Good Practice	Met / partly met / not met ?	Position Statement
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 with minimal ongoing effort - Information can be traced to source and is signed-off by owners	Met	Divisional Clinical Quality Groups review information about quality - e.g. incidents, complaints, audits. Trust prioritises participation in national audits and process is now in place for Medical Director agreement of participation in new national audits. Specialty clinical audit programmes are prioritised according to areas of high risk. Trust participates in all nationally required data validation and audit processes and has achieved positive scores for data quality.
	▪ 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	Met	As above - not all clinical audit activity results in action plans - clinical audit team request audit reports and action plans and track actions from recommendations of national audits.
	▪ There are no major concerns with coding accuracy performance	Met	UHB does very well in the annual coding audits - Informatics can provide evidence.
4c: Is quality information being used effectively?	▪ Information in Quality Reports is displayed clearly and consistently	Met	
	▪ 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)	Met	Performance metrics are always RAG rated and exceptions are compared with historic performance. Where relevant benchmarking is used. IG - Quality Report indicators are not all RAG rated - some e.g., missed doses are and are reported in KPI reports.
	▪ Information being reviewed must be the most recent available, and recent enough to be relevant	Met	Performance information reviewed by the Board is for the latest available month, quarter or year, dependent on the indicator.
	▪ 'On demand' data is available for the highest priority metrics	Met	Trust performance dashboard shows up to date data that can be broken down to at least service line level for the Trust's highest priority metrics.
	▪ Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate)	Met	Board performance report shows monthly absolute numbers for deaths of non-emergency patients.
	▪ Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance	Met	e.g., CQMG actions, quality improvement priorities etc.

Actions for Development
Plans to increase awareness of staff. Plan to develop newsletter and Inside Out article.
Propose a formal paper from Audit Committee to BoD to give assurance and promote discussion regarding risks.

Actions for Development
Head of Planning and Performance is working with stakeholders to review business case guidance and will ensure a quality impact assessment is a mandatory item. Assessment process for service changes not requiring business case to be considered.
As above.
As above.
Above process to include clear requirements for communication with and involvement of clinicians.

Actions for Development
Above process to include requirements for clear subsequent ownership.
Information about whistleblowing policy to be included on staff corporate induction to raise staff awareness of the policy. Above process to include ongoing assessment of impact on quality post-implementation.
As above.
As above.
As above.

Actions for Development
Trust quality priorities to be widely communicated to staff - e.g. via quality / governance newsletter.

Actions for Development
Clinical governance team has recently reviewed reports of national reports and inquiries. Clinical governance team to ensure ongoing monitoring and reporting of any relevant recommendations of high level inquiries. This will be further improved through review of Business Case guidance outlined above.
Could introduce more regular staff surveys to assess progress.
Introducing action/recommendation tracking software for actions arising from SIRI and complaint investigations, Exec RCA meetings, clinical audit would improve assurance.
Plan to communicate information about specific quality and governance topics, such as learning from incidents and complaints, quality priorities, CQUINs, QuORU etc.

Actions for Development
Some elements of the structure are currently being implemented. Patient Safety Group to be established, review of Clinical Quality Monitoring Group (CQMG) links to Divisional Governance arrangements is underway.
To review escalation process for SIRIs and complaints.
Plan to trial use of Datix for monitoring action completion from incidents and complaints. To consider reporting on action completion rates for SIRIs and complaints at Board, as well as at Divisional Clinical Quality Groups.

Actions for Development
Many (but not all) specialties have clinical audit programmes in place setting out high priority audits. Clinical audit team have been tasked with following this up for all specialties for 2011-12. Greater incentives for clinicians to complete clinical audit action plans would be helpful - e.g. as part of appraisal process. Planned new audit database would assist with reporting and monitoring.
Governance and risk presentation at corporate induction to include information about whistleblowing policy.

Actions for Development
To consider development of local, regular staff surveys or feedback mechanisms.

Actions for Development

Actions for Development
Clinical Governance Facilitators are currently reviewing Divisional groups and will be meeting Divisional Directors to clarify requirements and develop dashboard reporting. Clinical audit team have been tasked with setting up process for monitoring audits from SIRIs and with requesting audit programmes from specialty leads for 2011-12.
As above - greater incentives for clinicians to complete clinical audit action plans would be helpful - e.g. as part of appraisal process. Potential new audit database may assist with reporting and monitoring.