Whittington Health NHS

ITEM: 11
Doc: 07

Trust Board

DATE:	**23 May 2012**

TITLE:	**Monitor Quality Governance Framework –Action plans**

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PURPOSE OF REPORT: ***To discuss and agree the 'rag rating' of Monitor's ten quality domains***

EXECUTIVE SUMMARY:

The Monitor quality self assessment framework for aspirant foundation trusts is an initial step in the Foundation Trust assessment process. The purpose of the framework is to allow the organisation to assess performance and compliance against the ten quality governance domains. Evidence has been gathered to support good practice examples that have been provided against the quality domains. Consultation has taken place between divisional and operational leaders and executive directors. A preliminary self assessment and rag rating was undertaken at an extraordinary quality governance meeting and has been confirmed by the executive committee.

Action plans have now been drawn up to address any areas that were rated below green. These are attached along with the most up to date version of the Quality Governance Framework.

PROPOSED ACTION: Approval of action plans

APPENDICES:

DECLARATION
In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:

Implications for the NHS Constitution, CQC registration
Financial, regulatory and legal implications of proposed action
Risk management, Annual Plan/IBP
Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals

Supporting Information

NHS London

Aspirant Foundation Trust Pipeline Assurance

Template for NHS Trusts' Self-Assessment against Monitor's Quality Governance Framework

Section One – Guidance

v1.1 8 March 2012

Introduction and how to use this pack

In February 2012 the Department of Health published Part 1 of the Single Operating Model for SHA Clusters, focussing on the SHA Development Phase of the Foundation Trust (FT) Assurance process. One requirement of this process is that aspirant FTs undertake a self-assessment against Monitor's Quality Governance Framework and have that assessment independently reviewed. The expectation is that an action plan would be drawn up to address any identified gaps or areas for development.

NHS London has produced this tool to assist NHS trusts undertake and record this self assessment. The pack is in two parts:

➢Section 1 – includes this introduction, an overview of Monitor's Quality Governance Framework, the risk rating and scoring methodology to be applied and guidance notes.

➢ Section 2 – a template to record the results of your self-assessment. This is structured around the points of good practice that Monitor identifies for each of the 10 domains in the framework. It enables you to record:

(a) How you meet these areas of good practice (and the methodology you have used to determine this), an overall conclusion and assessed risk-rating* for each domain
(b) Where development is needed, action planned and key milestones
(c) A summary of your assessment and overall score*

**applying the guidance in Section 1, page iv*.

After completing the assessment and determining further action required the RAG risk-rating for each of the 10 domains together with an overall conclusion should be inserted into the "Overall Self-Assessment Summary"(Section 2, page 1). The individual scores for each domain derived from the risk-rating should be totalled to give the overall self-assessment score.

Your self-assessment and the resultant action plan should be shared with NHS London. Following review of the self-assessment NHS London will discuss with the Trust and the independent supplier any areas where it is felt a particular focus in the independent review would be useful and will also discuss the findings from the review. The outcome will inform the quality and safety assurance process for your FT application, which is led by NHS London's Medical Director and Chief Nurse. NHS London will monitor progress of your action plan as you progress through to submitting your FT application to the DH.

The NHS London FT Programme Lead working with your trust will have discussed the timing of this activity with you ahead of sending this pack. If you have any questions or need any further advice about use of this tool please contact your NHS London FT Programme Lead in the first instance.

Monitor's Quality Governance Framework

The diagram below gives an overview of the 10 domains within the framework:

Strategy

- 1A Does quality drive the trust's strategy?
- 1B Is the Board sufficiently aware of potential risks to quality?

Capabilities and Culture

- 2A Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?
- 2B Does the Board promote a quality-focused culture throughout the Trust?

Processes and Structures

- 3A Are there clear roles and accountabilities in relation to quality governance?
- 3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
- 3C Does the Board actively engage patients, staff and other key stakeholders on quality?

Measurement

- 4A Is appropriate quality information being analysed and challenged?
- 4B Is the Board assured of the robustness of the quality information?
- 4C Is quality information used effectively?

How to risk rate and score the self-assessment

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

Further information can be found on page 19 of the document *Applying for Foundation Trust Status: Guidance for Applicants* (July 2010):

http://www.monitor-nhsft.gov.uk/sites/default/files/Amendments%20to%20Applying%20for%20NHS%20Foundation%20Trust%20Status%20July%202010_2.pdf

Guidance notes

Monitor defines quality governance as **"the combination of structures and processes at and below board level to lead on Trust-wide quality performance[1]"** including, *e*nsuring required standards are achieved[2], investigating and taking action on substandard performance ; planning and driving continuous improvement; identifying, sharing and ensuring delivery of best-practice ; identifying and managing risks to quality of care

In the self assessment applicants should either describe how they comply with good practice or explain how and why they take a different approach. Evidence should show not just that quality governance processes are in place but also how effective they are - do they work in practice? do they deliver good outcomes? Evidence should show whether systems and processes are universally embedded, understood and used, not just that the wording exists in guidance documents, policies etc. Therefore what is being sought via this assessment is evidence of robust Board-to-ward-to-Board processes through which issues are raised, considered, acted upon and then "operationalised", with all staff aware of changes in policy and procedure and what that means for them. Applicants should also describe the methodology they have used to carry out their self-assessment, showing how they have triangulated information in order to ensure they are able to evidence of these Board-to-ward-to-Board processes.

In recent presentations to FT applicants Monitor has shared lessons learnt about self assessments and FT applications relevant to quality governance. An important message from this is that FT applicant trusts generally self-assess their risk-ratings against the 10 domains lower (better) than Monitor 's assessment. NHS Trusts are encouraged to self-assess candidly , to really challenges themselves and to triangulate evidence from different sources and different levels of the organisation in determining how robust systems and processes are.

Undertaking this self assessment at an early stage enables areas for development to be identified and addressed during the course of the FT application development. Some examples of issues that it might be helpful to consider in your self- assessment are noted below. In all cases, whatever the answer, a key questions to ask is : how do you (the Board) know?:

1.Are staff comfortable raising concerns and able to raise any type of concern?
2.Are governance structures clear and the purpose of committees etc. well understood?
3.Is the Board made aware of issues in a timely manner?
4.Do Board members routinely triangulate information received (by whatever route) and explore inconsistencies revealed by this?
5.Is the impact of decisions and actions on quality understood?
6.Do communication channels exist that mean every member of staff can access information relevant to them (24/7)?
7.Are NEDs fully involved, do they meet staff and patients regularly and can they triangulate the information given in Board papers with what they hear directly from staff and patients?
8.How does the Trust compare with the best, and what is the rate of improvement? Does the Trust benchmark against good practice standards and other organisations?
9.Are complaints, claims and incidents triangulated with lessons learned agreed and then acted upon?
10.Are action plans to deliver improvements SMART and are arrangements for monitoring effective?

[1] Quality performance incorporates safety, clinical effectiveness and patient experience and is measured across inputs, processes and outputs
[2] Required external standards include, but are not limited to: legal requirements for on-going registration with CQC; satisfaction of agreed levels of service provision; and delivery against national targets and standards (Appendix B of Compliance Framework)

Whittington Health

Self-Assessment against Monitor's Quality Governance Framework

Section Two - Outcome
[Insert date]

v1.1 8 March 2012

Overall summary

Please record below your assessed risk-rating and associated score* for each of the 10 domains and the total score for the overall assessment. Please provide a summary of the key findings and conclusions from your self-assessment in the box provided.

Domain	RAG/Score		Summary assessment
1a		0	The board uses strategy effectively to define, develop and monitor quality goals and to drive improvements in quality improvement, performance and patient experience across the organisation. There is clear strategic direction for quality across the organisation and up and down the organisation. The membership of Trust Board represents another key strength for the organisation and in terms of board leadership, the diversity and breath of experience and expertise of the membership provides a rich field for appropriate challenge for the executive directors. Areas identified that require further development to achieve a 'green' rating relate to an awareness of 'capability and culture'. Trust Board recognises that it could strengthen skills and knowledge in order to facilitate driving forward and leading the quality agenda. A board development programme is in place in order to enable this. Some areas of weakness have been identified in relation to 'measurement', in terms of the robustness of the data quality and information scrutinised. An action plan is now in place to address these concerns . It is recognised however, that quality dashboards are in a state of evolution and will continue to evolve and change in response to local and national priority. Further work is needed to improve the responsiveness of data scrutinised in order to ensure it is as 'live' as possible to ensure real time analysis and subsequent management of risk around the data presented to trust board.
1b		0	
2a		0.5	
2b		0	
3a		0.5	
3b		0	
3c		0	
4a		0	
4b		1	
4c		0.5	
Overall score	N/A	2.5	

*See guidance and links to further information in Section 1, page iv.

Methodology

Please describe below the methodology you have adopted in order to carry out your self-assessment.

Description of the methodology used to carry out this self-assessment and who has been involved
Compliance against the quality domains have been assessed by divisional directors, operational directors , executive directors and their teams and they have self-assessed their performance against these standards and provided evidence to support their decisions.

*See guidance in Section 1, page v.

Strategy

1a. Does quality drive the trust's strategy?

Good practice	How can you evidence these areas of good practice?
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 7. AFT's are able to demonstrate that the quality goals are effectively communicated and well-understood across the trust and the community it serves 8. The board regularly tracks performance relative to quality goals	•1. Whittington health strategy provides high level organisational goals 1. Education strategy drives quality across the ICO for both undergraduate and post graduate training and education 1.Workforce strategy drives productivity and drives quality through the reduction in agency use and appraisal of staff (SC) 1. Quality strategy provides quality objectives within safety, clinical outcomes and patient experience that are measurable and specifically defined to include ambitious 'stretch' plus demonstrate year on year improvement. (SS) 2. Quality goals derived from both organisational performance and national priorities (NHS Outcomes Framework (RL) ; Dr Foster, staff quality survey) 2. Quality goals in quality account selected to reflect national and local priorities 2. Divisional quality reports to the quality committee contain approved quality improvement goals, taken from the quality strategy. (THESE REPORTS IN DEVELOPMENT) These additionally support the overall trust wide strategy (RL) 3. Quality goals are selected using local intelligence such as complaints, incidents, claims and patient harm to ensure high level impact that comes with improvement programmes (SS, SC, CW) 4. Metrics for quality goals approved or in development (SMART objectives under development) (SS) 5. Divisional quality reports provide link with high level quality objectives and those agreed by the divisions (RL) 6. Action plans are evident and reported within the divisional quality reports to the quality committee (RL) 7.(IN DEVELOPMENT) Once strategy approved communication and dissemination plan to be agreed 8. Quality committee reports to trust board after each meeting (RL) 8 Specific examples included maternity SI investigation; review of ED performance; (bariatric service review (SC, LB) 8. QIPP performance data reported to the board monthly (RL) 8. Divisional quality and safety dashboards are presented to the board every month in the Quality Committee report (RL) EXAMPLES THAT INFORM THIS STANDARD: CQUINs (SS); sexual health and gynae service coming together; Skill mix review if district nursing (CG) Pentonville quality report to quality committee (SC) and ' death in custody report' from prison (RL); External review of the ED service

Overall conclusion	Assessed risk-rating:

Strategy

1b. Is the Board sufficiently aware of potential risks to quality?

Good practice	How can you evidence these areas of good practice?
1. The board regularly assesses and understands current and future risks to quality and is taking steps to address them 2. The board regularly reviews quality risks in an up-to-date risk register 3. The board risk register is supported and fed by quality issues captured in directorate/service risk registers 4. 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 5. There is clear evidence of action to mitigate risks to quality 6. Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment) 7. 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)	1. Board assurance framework (BAF) contains detail of areas of risk and evidence of how these risks are being mitigated. Internal investigation often instigated from the board around areas of concern e.g., deep dives into services such as maternity and Mercers. BAF presented to trust board quarterly and to each meeting of the Audit Committee. A 3 hour workshop of Audit Committee in march 2012 identified the three top risks on the BAF and considered these through a detailed deep dive approach (RL) 1.Executive committee review BAF every month (RL) Minutes of executive Comm meetings where this has been discussed (EW or IS) 2. Corporate Risk register is updated monthly and reviewed by Audit Committee and Trust Board quarterly 3. Risk management strategy stipulates the organisational process and approach to risk management 3. Divisional risk registers feed into corporate risk register- Risks higher than 16 are automatically entered onto the Corporate Risk Register and {removal or de-escalation is considered and approved by EC} (SS) 3. Risks defined within quality parameters; safety, experience and clinical effectiveness within corporate and divisional risk register. (RL) 4. Divisional risk registers include some examples of risks associated with new technologies (Describe process by which divisional risks are identified) 5. EXAMPLES THAT INFORM THIS STANDARD; Somali patient (CIC); classification of Ketamine as a controlled drug (SC); DNs action plan around pressure ulcer incidence reduction (RL); all risks on risk register have action plan around mitigation 5. Mercers action plan, Greentrees report (CG, RL) 6. CIP Board (provide examples). CIP template (Eleanor Hellier has example papers) (SC) 7.CIP Board and template to review service changes that may undermine quality •Ward quality dash boards allows internal benchmarking of KPIs for patient care and safety •NHS organisational health intelligence report •Productive ward outcome measures across wards (being re-launched) (SC) • Safety Express benchmarks across participating organisations using 4 KPIs (RL, ST) • Infection Control Dash Board • Visible Leadership audits •AREAS HIGHLIGHTED FOR DEVELOPMENT FOR INFORMATION- addressing health inequalities; improving patient pathways across the ICO

Strategy

1b. Is the Board sufficiently aware of potential risks to quality? (continued from previous page)

Good practice	How can you evidence these areas of good practice?
8. The board is assured that initiatives have been assessed for quality 9. All initiatives are accepted and understood by clinicians 10. There is clear subsequent ownership (e.g. relevant clinical director) 11. There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistleblower policy 12. Initiatives' impact on quality is monitored on an ongoing basis (post implementation) 13. Key measures of quality and early warning indicators identified for each initiative Quality measures monitored before and after implementation Mitigating action taken where necessary.	8 CIP Board . Example: cut in security staff vetoed by EC as identified risks to quality not acceptable. •Review of SAFE analysis • Quality Impact assessment of all CIPs (EH, SC) • 9. Evidence of clinician presence in CIP Board minutes •9. CIP identified where no progression or modification required due to clinical concerns ie bed closure programme – safety concerns led to modification of the CIP (EH) 10. All CIPs are agreed by the Divisional Directors and Divisional Operational Directors (inc evidence of discussion In Divisional Board minutes) (RL) 11. Whistle blowing policy available for staff on intranet 11. Staff survey; patient safety walkabout 11. CEO welcomes suggestions and concerns via Intranet Blog (RL) 11. DON operates open door policy for staff who have concerns STATEMENT 12. CIP initiatives monitored on a quarterly basis through CIP board. Eg ' bed closure projects (EH) 12. Quality impact of CIP on divisional performance(report from MdS) (RL) 12 CIP/ TOB Board forward planner to identify dates of Divisional Directors of ops presentations. (MdS) 13. Quest tool implementation for ward dashboards (early warning tool) and data dictionary and quality dashboard. (SS)

Overall conclusion	Assessed risk-rating:

Capabilities and Culture

2a. Does the board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?

Good practice	How can you evidence these areas of good practice?
1. 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) 2. The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board 3. 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.	1. Board seminar programme (SC, RL April) 1. NEDS are cross members of Audit committee and Quality committee (SC) 2. 1 clinical NED sits on quality committee and one NED chairs the quality committee (SC) 2 patient safety walkabouts supports 'capability' culture (RL) 2 The skill mix of the board membership enables the board to deliver and challenge the quality agenda (RL) 2 Deep dive report into ED discussed at Board (RL) 3. SUGGEST A SURVEY OF BOARD COMPLIANCE WITH THESE STANDARDS (SS) 3. All Board members have been appointed in line with job profiles and person specifications which included quality capabilities. A programme of board seminars includes quality governance, and the quality committee, a sub committee of the Trust Board, is chaired by one of the non executive directors, with other NEDs and directors participating as members. Board development programme being rolled out (Siobhan Harrington leading with JL) (RL) 3. Compliance with NICE guidance is monitored through the audit and effectiveness committee, which is currently reporting through the effective care committee to the quality committee. However, proposal is that the audit and effectiveness committee reports directly to quality committee. Exceptions regarding compliance to national standards will be reported to quality committee if they exist (SC) Deep Dives exploring concerns (RL) Deep dive outpatients proposal April 2012 Board discussion (RL) ED external review of performance Patient safety walkabouts by board members {including clinical framework used by non-clinical members of the Board} PI 3.Quality survey sent to board members (SS link) SPECIFIC PIECE OF WORK TO BE DEVELOPED WITH CHAIRMAN RE BOARD DEFINITION AND OPERATIONALISATION OF 'BOARD LEADERSHIP' Suggest NEDS to develop specific areas of responsibility (RL)

Capabilities and Culture

2a. Does the board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda? (continued from previous page)

Good practice	How can you evidence these areas of good practice?
4. 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) 5. The board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained 6. Board members have attended training sessions covering the core elements of quality governance and continuous improvement	4. Deep Dive on Maternity Services June 2011 – Review of complaints and Sis from 2010-2011 (SC, RL) 4. Quality Committee establishment 4. Death by Indifference – report in 2010. Agreement to employ LD consultant champion, staff workshops through 2011 (SS), review by board in March 2012 •4. BGAF case study on quality. Outpatients, ED and other examples (DS, RL) 5. BGAF-there is an action plan to restart succession planning **(a meeting is planned for 23/05)** 6. Board seminar series-(AGENDAS of these must be evident somewhere! Presentations, action notes etc) (SS)

Overall conclusion	Assessed risk-rating:

Capabilities and Culture

2b. Does the board promote a quality-focussed culture throughout the Trust?

Good practice	How can you evidence these areas of good practice?
1. The board takes an active leadership role on quality 2. The board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other trusts and external organisations) 3. The board regularly commits resources (time and money) to delivering quality initiatives 4. The board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by board members) 5. The board encourages staff empowerment on quality 6. Staff are encouraged to participate in quality / continuous improvement training and development 7. Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment) 8. Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery) Internal communications (e.g. monthly newsletter, intranet, notice boards) regularly feature articles on quality .	•1. NED chairs the Quality committee; 1 NED on CIP Board-(Robert Aitken) 2. Example: Torbay –integrated care pathways; learning from Aintree EPR; Mid Staffs report, Six Lives; 2. Chairman's involvement in OP work (Adam Smith) 3. Recent approval of business case for ED and pharmacy weekend cover 4. patient safety walkabouts; hospital chairman attendance at visible leadership programme NEDS with specific responsibilities e.g. ethnic minority (could be developed for other NEDS) 4. Chairman's involvement with outpatient work 5.Values work (staff questionnaire on quality; open workshops) 5. Board seminars include presentations from staff in relation to quality of services. Board involved in staff engagement events which give staff opportunity to contribute to strategic goals and values ie NEDs and Chairman engaging with staff (lunchtime); staff presence at QIPP Board 6. Voice from the Floor; participation in UCLP quality forum; clinical audit awards; improvement methodology training undertaken by senior staff 6 EXAMPLES OF GOOD PRACTICE: 6. Staff mandatory training; Band 6 development programme (CB); Staff on Institute of improvement programme- Linda McGurrin; UNIPART work (Matthew Boazman); Darzi fellow work;Ward managers leadership programme (EMM C and MP);Quality survey (SS); Service line reporting for Quality Account; Reduced mortality due to cardiac arrest and deteriorating patient work; GMC survey feedback re undergraduate and post graduate education Values exercise by CEO and director of people;Services contributed to quality account 7. Annual staff survey Trust score same as national average for acute trusts 2011. 8. Message of the month in maternity; CATS eyes; Bulletin ; RCN leadership programme 8. Message of the month in maternity; CATS eyes; Bulletin ; Ward Sr leading on FALLS, Meyrick staff 8.Investors in people award 2011 (MB) have developed a body plan for use in handover to identify risk of pressure ulceration, AREAS OF DEVELOPMENT REQUIRED: NEED TO STRENGTHEN BOARD TO FLOOR TO BOARD COMUNICATION-Helping staff to consider organisational changes and board decisions through a 'quality lens'; Chairman to re-commence monthly Chairman's piece 'report from the board' in trust communication (Bulletin or Whittington express); Comms to reintroduce cascade system of board information Communication strategy

Overall conclusion	Assessed risk-rating:

Structures and processes

3a. Are there clear roles and accountabilities in relation to quality governance?

Good practice	How can you evidence these areas of good practice?
1. Each and every board member understand their ultimate accountability for quality 2. 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) 3. 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 4. Quality performance is discussed in more detail each month by a quality focused board sub-committee with a stable, regularly attending membership	1. GAP – evidence ascertained from interview/ observation 1. Appraisals of exec and non exec director are available from HR 1.JDs of exec directors and non exec directors (MB) 2. Organisational structure charts and committee structure charts 2. Individual Quality responsibilities within the organisation - organanagram 2. Board escalation framework under development 2 Example of structure for dissemination of information from CG-(TOB and DMT operational meetings with service leads on performance and quality (CG) 2. Job descriptions provide clear lines of accountability and reporting structures 2. TOR of committees provide reporting lines through to the board 2. Executive directors have portfolio of quality areas (BS and CIC) 2. TORS divisional boards (divisional directors) 2.Revalidation process and policy 2.JD of ward manager and matrons as examples of quality focus 3. Executive Board Template being Amended to include Quality Governance Components, Targeted for January 2012 3. Standing agenda item on trust board 'quality and safety' Formal monthly Quality Report to the TB 4. Quality committee (sub committee of the board-detailed quality agenda) MINUTES OF MEETINGS) 5. Risk management strategy defines roles and responsibilities regarding patient safety

Overall conclusion	Assessed risk-rating:

Structures and Processes

3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?

Good practice	How can you evidence these areas of good practice?
1. 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. 2. 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: • Designated owners and time frames • Regular follow-ups at subsequent board meetings 3. 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 4. 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	1 SI policy; risk management strategy; board escalation framework in progress (DW); complaints policy 2 SI panel; SI have action plans; complaints have supporting action plans; SI action plans to be reported to patient safety committee bi-monthly 2. Move to identify implications arising from SI RCAs for all divisions – through Exec SI Group eg actions form ED Information Breach relevant to all divisions 2. Capability policy and disciplinary procedures 2. Managing concerns about drs performance policy 3 Death reviews (CIC) 3.ED performance issues (CG) 3. Action plans around information governance Sis (CG) 4 visible leadership programme 4 voice from the floor 4 clinical audit programmes now divisionally led 4. Quality committee TORS. Oversight of quality performance 4 Internal audit (PARKHILL) 4. Clinical audit strategy and divisional clinical audit programmes 4. Annual staff survey 4. Whistle blowing policy 4.Divisional board meetings

Structures and Processes

3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance? (continued from previous page)

Good practice	How can you evidence these areas of good practice?
1. A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle 2. 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	1 Whistle blowing policy evident 1. Risk management strategy outlines structures and processes 2 Capability policy in operation 2 CEO staff award, include awards for team and individuals 2 Annual clinical audit awards 2. Nursing grand round-celebrating excellence in research and Innovation 2. Staff appraisal and medical appraisal 2.Medical appraisal policy

Overall conclusion	Assessed risk-rating:

Structures and Processes

3c. Does the board actively engage patients, staff and other key stakeholders on quality?

Good practice	How can you evidence these areas of good practice?
1. Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance 2. 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) 3. 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	1 Quality Account is published on internet website 1. Trust Board papers published on internet 1.Trust annual meeting 1. Patient experience committee provides strategic direction 2. Governors work on 'patient mapping' and patient experience (maternity project) 2. Links and Governor on quality committee 2.Patient experience group 2.Patient experience strategy (DRAFT?) Matron's conversations (visible leadership patient survey) 2. Patient stories. LD story to TB in March 2012. pressure ulcer story April trust board 2. Director of Nursing walk-a bouts with NEDS at the weekend (BS) 2 Patient safety walkabouts 3 monthly CEO briefings 3 Board review of staff survey and action plans to address problem areas 3 Staff quality survey; annual staff survey 3.VL leadership audits 3.PALS 3.Health watch EXAMPLES OF GOOD PRACTICE: direct involvement of patients/service users in pathway re design such as the colorectal service (MK) and co-creating health ;chairman's coffee mornings

Structures and Processes

3c. Does the board actively engage patients, staff and other key stakeholders on quality? (continued from previous page)

Good practice	How can you evidence these areas of good practice?
4. The board actively engages all other key stakeholders on quality, e.g.: • Quality performance is clearly communicated to commissioners to enable them to make educated decisions • Feedback from PALS and LINks is considered • For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway • The board is clear about Governors' involvement in quality governance	4. Regular commissioning engagement on quality through Clinical Quality Review Group NCL 4. Active engagement with LINks for patient feedback eg. – Unannounced visits to audit meal times 4.PALS information reported to Patient Experience Group/Quality Committee through aggregated reporting on Incidents, Complaints, Claims, PALS 4 CEO engagement work with GPS (Eileen Willis?) 4. Haringey integrated network board (chaired by Andrew Williams) 4. Monthly GP commissioners operational meeting with services (CG) (Care pathways need to explore with Divisions, Greg Battle, Siobhan Harrington re GP engagement). 4.David Seabrooke/Fiona Smith to comment on Board clarity on Governors involvement 4. Development of CCG Transformation Board- there is transformation project plan (Lisa Crawley has this) work led by Fiona Yong Question: Are the board clear about the Governors' role?

Overall conclusion	Assessed risk-rating:

Measurement

4a. Is appropriate quality information being analysed and challenged?

Good practice	How can you evidence these areas of good practice?
1. 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 2. 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	1. Monthly Board Performance Dashboard and reporting from Quality Committee and supporting dashboards, metrics for quality dashboard include, Safety/Clinical Effectiveness and Patient Experience (further development required) 1.Advance warning indicators in Quality Dashboard identified within data dictionary (further development required) 1.Global Trigger Tool utilised on Wards? (Plan to include this data on quality dashboard) 1. SI and Incident Reporting, Complaints Reporting and Aggregated Reports of Incidents, Complaints, Claims and PALS Analyses at Quality Committee 1. Best Practice Pathways? 1. Quality Dashboards include qualitative descriptions to back up quantitative information (further refinement required for Divisional Granularity) 2. Quality Strategy Board Approved 2. Board Members knowledge of data dictionary (further development) and associated quality priorities see further bullets. AREA FOR DEVELOPMENT- refinement of dashboards-(Tower hamlets are very good at this)

Measurement

4a. Is appropriate quality information being analysed and challenged? (continued from previous page)

Good practice	How can you evidence these areas of good practice?
3. The board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines 4. Quality information is analysed and challenged at the individual consultant level 5. 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	3. Board Dashboard cascades to Quality Dashboard and Divisional Dashboards? Reported down through the organisation, minutes of Quality Committee, Divisional Boards review of dashboards 4. Consultant appraisal and job plans 4. CEOs 'hall of shame' 4. Urology peer review 4. Women's Health peer review 4. Oncology peer review 4. Anaesthetics peer review? Hassan Mukhtar-reducing variations in practice work as an example 5.? BGAF response for this.

Overall conclusion	Assessed risk-rating:

Measurement

4b. Is the board assured of the robustness of the quality information?

Good practice	How can you evidence these areas of good practice?
1. 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 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 2. There are no major concerns with coding accuracy performance	1.FS/ MdS to comment on this re clearly documented controls to assure ongoing information accuracy, validity and comprehensiveness 1. Divisional Board Terms of reference defining governance arrangements and assurance on quality of performance/quality data? • Clinical Audit program is driven by National Audits, additional audits identified based on regional and local service priorities or from intelligence from Incidents and Investigations. 1.Electronic Systems, FS, Anita Garrick to comment. 1.Safety elements and Patient Experience Complaints PALS/Inquests via Datix structure reporting and data collection. • Traced to source and signed off by owners, This links to the information governance took kit data mapping. FS 1. Audits include formal action plans and monitored either at divisional/service level. Re audits completed for national audits and locally determined audits. 1. Divisional clinical audit programmes; high compliance with national audits 1. Audit and effectiveness committee scrutinise and approve audit programme 1.Clincial audit strategy in place 2. Coding accuracy performance FS/AG to comment.

Overall conclusion	Assessed risk-rating:
There are elements of assurance but lack of robust data systems. Ownership of data would improve accountability as quality assurance responsibilities would be more clearly defined	

Measurement

4c. Is quality information being used effectively?

Good practice	How can you evidence these areas of good practice?
1. Information in Quality Reports is displayed clearly and consistently 2. 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) 3. Information being reviewed must be the most recent available, and recent enough to be relevant 4. 'On demand' data is available for the highest priority metrics 5. Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate) 6. Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance .	1. Development area -some inconsistencies in Quality Dashboard and Qualitative Supporting Reports 2. Information is RAG rated and is supported by Data Dictionary (some development required to this). 3. This needs clarity in terms of definition, there is a data lag between production of data and reporting timeframe (2 months) judgement on this required! 4. FS/AG to comment on this (on demand data available for SI/Incidents, Complaints, Claims and PALS. 5. Dashboard uses Dr Foster Summary Data, Dashboard captures Serious Incidents, SI reports captures more granular information for humanised/personalised information on dashboard 6. Further discussion from Quality Committee members required for this perspective 6 EXAMPLES: Pressure ulcers work; consultant staff in ED;DN in Haringey; quality objective based upon performance data such as reducing falls associated with harm and compassion and dignity as priorities in quality account from patient survey

Overall conclusion	Assessed risk-rating:

Areas for development and action plan

Domain	Risk rating	Areas for development	Key actions and milestones
Strategy 1a. Does quality drive the trust's strategy?	0.5	Dissemination of quality objectives to staff from the board needs development. As many of the major quality strategic documents are still in development (quality strategy and quality account) a dissemination plan has yet to be agreed to ensure that all staff are aware of the top three quality objectives and the trust's overall approach to quality improvement	**LEAD – Celia Ingham- Clark and Bronagh Scott** Dissemination plan to be drawn up re quality goals and objectives to include social media, public and internal dissemination through trust website, Face book and Twitter as well as internal publications Publication of Quality Account (June 2012) Publication of Quality Strategy(imminent) Agreement of metrics for all quality goals in quality strategy
Strategy 1b. Is the Board sufficiently aware of potential risks to quality?	0	Generally this was thought to be a area of good performance. Structures and processes could be strengthened to enable all staff, at all levels to recognise and escalate risks to quality.	**LEAD-Celia Ingham- Clark and Bronagh Scott** Board escalation framework (in development) Education for staff around what a risk to quality might look like to allow early identification of risks to performance, reputation and business objectives.

Areas for development and action plan

Domain	Risk rating	Areas for development	Key actions and milestones
Capabilities and culture 2a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	0.5	This was scored amber/green as although there is a Board development programme in place, it is currently an area of development. To develop a culture of openness, learning, trust and transparency among the board membership	**LEAD-YiMien Koh and Joe Liddaine** Board survey to be completed assessing opinion of Board capability and capability in leadership and challenge around quality performance
Capabilities and culture 2b. Does the Board promote a quality-focused culture throughout the Trust?	0	This was felt to be a strong area given the activities of the executive directors and the NEDs with examples provided of quality initiatives at all levels of the organisation plus wide participation from the NEDS in quality activities. Quality leadership initiatives are in place at all levels of the organisation including healthcare assistant level, and initiative that is about to start. Staff feel comfortable reporting harm and errors but need further support to recognise and escalate other threats to quality and this is a recognised area of devel0poment	**LEAD-YiMien Koh and Joe Liddaine** Board development programme

Areas for development and action plan

Domain	Risk rating	Areas for development	Key actions and milestones
Processes and structures 3a. Are there clear roles and accountabilities in relation to quality governance?	0.5	This element was scored cautiously. It was felt that there was very clear accountability around the quality agenda at all levels of the organisation but perhaps there could be more clarity around responsible individuals particular areas of focus. The quality committee provides robust challenge around quality data and provides assurance to the trust board on all elements of quality and performance. Greater clarity is needed regarding roles and responsibilities of specific staff	**LEAD-Bronagh Scott** Board escalation framework Quality organagram?
Processes and structures 3b.Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	0	An area of good performance. There are clear strategies, processes and structures to support staff at all levels within the organisation to escalate concerns, complaints and incidents. There is a strong clinical audit programme to monitor performance and compliance with best practice. The clinical audit programme could benefit from strengthening in terms of its measurement of integrated care standards and the programmes will need to evolve to reflect the integrated patient journey. This should be aligned with the evolution of integrated care pathways The TORS for the audit and effectiveness committee have recently been strengthened to reflect the importance of clinical audit in providing support in the delivery of high quality services. This committee will now report directly into the quality committee in recognition of its quality function. Each clinical audit lead will be provided with a specific agreement that outlines their responsibilities within the role of clinical audit lead as part of this work.	**LEAD-Bronagh Scott** Further development of clinical audit programmes to reflect integrated care Finalising changes in reporting structures of the audit and effectiveness committee Agreements for clinical audit leads that outline their roles and responsibilities

Areas for development and action plan

Domain	Risk rating	Areas for development	Key actions and milestones
Processes and structures 3c. Does the Board actively engage patients, staff and other key stakeholders on quality?	0	Areas of good practice were noted in the area. Board patient stories provide powerful accounts of the quality of patient experience to bring to life elements of good and poor practice from those who directly are affected.	**Bronagh Scott and Siobhan Harrington**

Areas for development and action plan

Domain	Risk rating	Areas for development	Key actions and milestones
Measurement 4a. Is appropriate quality information being analysed and challenged?	0	Continue to amend quality dashboard to reflect new areas of local and national concern.	**LEAD-Maria da Silva and Bronagh Scott**
Measurement 4b. Is the Board assured of the robustness of the quality information?	1	This standard reflected the area of most concern to the organisation. There is a time lag of two months from the time performance and quality data is produced and reviewed by Trust Board. This needs to be improved There is lack of ownership of the data and assurance responsibilities However, there are SOPS on data validation in place to ensure the quality of data A new post has been developed to lead on data quality and performance as this is a recognised area that requires improvement	**LEAD-Maria da Silva** Production of more real time data required Strategy needed to strengthen alignment of quality information up and down the organisation –ensuring a good fit of all quality data at different levels; from ward to board to ward.

Areas for development and action plan

Domain	Risk rating	Areas for development	Key actions and milestones
Measurement 4c. Is quality information used effectively?	0.5	**The narrative provided to support quality metrics in some cases does not fit the quantitative profile reported. Interpretation of quality data needs to be improved.** **The time lag in data generation and data review results in a two month gap as already stated and this is too long .** **Data reports need to be more responsive and immediate to allow real time assessment** **To spread understanding of normal statistical variation , including use of statistical process control charts among those responsible for compiling quality reports** **To share divisional quality reports down to individual service lines to ensure ownership of the data and focus clinicians on areas where quality improvement is needed.**	**LEAD_ Maria da Silva** **Data quality performance post being developed (FS and MDS)**

Completion checklist

Action	Date	Comment
Self-assessment agreed by the Board		
Areas for development, actions and milestones agreed by the Board		
Self-assessment slide pack completed		
Completed slide pack shared with the independent review supplier		
Completed slide pack submitted to your NHS London FT Programme Lead		
Trust contact	Name:	
	Designation:	
	Email:	
	Tel:	

Lead: Chairman and CEO: capabilities and culture 2a

Domain	Risk rating	Area for development	Actions	Lead	Timescale
Capabilities and culture	0.5 (Amber/Green)	This was scored amber/green as although there has been a programme of board development, it is currently an area of development	1. Board survey to provide base line for areas of specific focus to further inform the board development programme	Assistant Director of Research, Innovation and Quality	Completion May 18th
2a Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?		To develop the effectiveness of the Board and ensure a highly performing Board that will lead Whittington Health as a Foundation Trust	1. Board development continues through Seminar programme including Myers Briggs profiling. 2. Board development programme to be completed, incorporating feedback from survey	Chairman/ Director of Strategy/Deputy CEO	Seminars monthly Programme agreed by end of May 2012

Lead: Director of Nursing and Patient Experience

Domain	Risk rating	Areas for development	actions	timescales	Leads
Processes and structures	0.5				
3a. Are there clear roles and accountabilities in relation to quality governance		Greater clarity is needed regarding roles and responsibilities with clear escalation processes .	Board escalation process to be agreed	June 2012	Director of Nursing and Patient experience/AD of governance

Lead: Chief Operating Officer and Director of Nursing and Patient Experience

Action plan

Domain	Risk rating	Areas for development	Action	Timescale	Lead
Measurement					
4b Is the board assured of the robustness of the quality information?	1	1. There is a time lag of two months from the time performance and quality data is produced and reviewed by Trust Board. This needs to be more timely and as live as possible	1. A new 'performance manager' post has been approved. A full analysis of the current systems and processes for data capture and report will be undertaken by this manager and digital performance dashboards developed ensure timely and effective performance reporting from Board to floor to Board.	1. Appointment of position has been agreed. Person to be in post by June/July 2012	Chief Operating Officer
4c Is quality information being used effectively?		2. There is lack of ownership of data and assurance responsibilities	2. There needs to be clear corporate responsibility agreed for Quality Dashboard	2. To be clarified by June 2012	Chief Operating Officer and Director of Nursing
			2. A complete review of current committee structures is in train to clarify TORS of committees that report to Quality committee and other feeder committees	3. To be complete 30th September 2012	Director Nursing and Patient Experience/Assistant Director of Governance

Continued from previous page			to rationalise data flow into those committees and how information is reported up and down the organisation.		
		4. Data is currently being sourced from different systems, by various people and being analysed more than once with different context therefore there is a greater risk of confusing reports which are not integrated	4. A systematic review of data gathering processes and reporting systems and performance information flows will be undertaken by the Performance Manager to reduce variation and error.	4. To complete by August 2012	Chief Operating Officer/ Director of Planning and Programmes
			4. A business case needs to be developed to support the acquisition of a data management system to manage the flow and quality of data required for governance compliance across the organisation	4. To be complete by 31st May 2012 (Business case complete)	Director of Nursing and patient Experience/Assistant Director of Governance/Director of IT
			4. Data sources will be rationalised into the new electronic patient record where possible	4. As per electronic patient record implementation programme	Chief Operating Officer/ Director of IT/Director of Programmes and Planning