The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25TH September 2013 **ENCLOSURE NUMBER: 7**

REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Lindsey Webb** **Director of Nursing and Governance**
SUBJECT:	**Quality Governance Framework (QGF)**

BACKGROUND

At the Board workshop in August 2013 to undertake the self-assessment against Monitor's QGF Board members:

- Received a presentation from colleagues at Monitor on the QGF
- Reviewed the QGF and previous self-assessments
- Discussed and identified assurances and areas for further work
- Requested the executive team undertake a more detailed piece of work that would enable all Board members to have a better understanding of the assurances and areas for further work during 2013/14

This piece of work has now been completed, the output of which is provided in this paper.

RISKS

The Board has to confirm in each quarterly declaration to Monitor that it has completed a self-assessment against the QGF and has met the required standard for aspirant FTs i.e. a score of not greater than 3.5.

RECOMMENDATIONS

The Board are asked to:

- **Approve** the self-assessment score against the QGF
- **Note** the associated action plan
- **Agree** to continue the quarterly review process by IGC for presentation to the Board to inform each declaration

QUALITY GOVERNANCE FRAMEWORK SEPTEMBER 2013

SUMMARY

		Q2	Q3	Q4
1. Strategy	1aDoes quality drive the trusts strategy	Green = 0		
	1b Is the Board sufficiently aware of the potential risks to quality	Green = 0		
2. Capabilities and culture	2a Does the Board have the necessary leadership , skills, knowledge to ensure the delivery of the quality agenda	Green = 0		
	2b. Does the Board promote a quality focused culture throughout the trust	Green = 0		
3. Processes and structures	3a Are there clear roles and accountabilities in relation to quality governance	Amber = 0.5		
	3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance	Amber = 0.5		
	3c. Does the Board actively engage patients and staff and other key stakeholders in quality	Amber = 0.5		
4. Measurement	4a Is appropriate quality information being analysed and challenged	Amber = 0.5		
	4b Is the Board assured the of the robustness of the quality information	Red = 1.0		
	4c Is quality information used effectively	Amber = 0.5		
Total score		3.5*		

*Score of 3.5 or less required for Monitor authorisation

SELF ASSESSMENT AND ACTION PLAN

		Examples of assurance	Gaps	Actions required	Lead	Date	Update	Current score
1 Strategy	1aDoes quality drive the trusts strategy	Quality Account Corporate performance report CQUINs Contract targets Monitor annual plan Quality metrics key priority in performance meetings Engagement of stakeholders in development of Quality Account	Annual business plan Directorate objectives coming from annual business plan Identifying and developing future medical leaders Improve engagement of staff, patients and stakeholders in the quality agenda	Complete annual business plan for current year Complete annual business plan for 14/15 Establish directorate objectives for 14/15 Communicate the annual business plan across the organisation Develop medical leadership programme Ensure that the quality agenda is part of engagement strategies with all parties	LW GB GB GB AG/AP GB	August 2013 December 2013 March 2014 September 2013 March 2014 October 2013	Complete	G
	1b Is the Board	BAF/CRR	Board approval of 13/14 BAF	Board approval of BAF	LW	August 2013	Complete	G

	sufficiently aware of the potential risks to quality	IGC/Audit Committee review of BAF/CRR Initial and ongoing quality impact assessments of CIPs Whistleblowing policy Evidence that staff concerns are investigated and addressed (HDU)	Systematic post implementation evaluation of projects Regular benchmarking of nurse/Dr staffing levels Use of internal audit function to provide overview of quality governance Ensure terms of reference for Board and sub-committees are fit for purpose with regard to quality governance Link between clinical audit programme and internal audit programme ensuring both	All PMO/CIP projects to have formal post implementation review Complete nursing skill mix review and repeat annually Complete benchmarking of Dr staffing levels Include quality governance in internal audit programme Review Terms of reference for Board and its sub committees Review clinical audit/internal audit programme against annual business plan to ensure links to quality agenda.	PA LW AP LW JS LW/PA	September 2013 December 2013 March 2013 October 2013 September 2013 October 2013		

			are aligned to quality agenda					
2. Capabilities and culture	2a Does the Board have the necessary leadership , skills, knowledge to ensure the delivery of the quality agenda	Board undertakes annual review of NED and ED performance through appraisals. Quality is covered within this. Chair of IGC and fellow committee members are key to providing assurance through their quarterly declarations. Skills gaps identified when vacancies arise.	Agreement of regular 3 yearly whole board review criteria	Chairman to consider board review	BJ/JS	Feb 2014		G
	2 b Does the Board promote a quality focused culture throughout the trust	Board agenda Board comms via CEO briefing; Directorate presentations on quality. Key focus on clinical audit and outcomes through COEC up		Improve score on staff survey with regards to responsiveness to incidents in particular. Use the action plan associated with this to track against milestones.	AG/LW	Ongoing and as per action plan for staff survey.		G

		to board via IGC. Walkabouts and team buddying						
3. Processes and structures	3a Are there clear roles and accountabilities in relation to quality governance	Directorate Structure through which Service Line Management is delivered. TBALD implemented with a standardised agenda for Directorate meetings including SIRI feedback as well as HR, finance. Quality and service performance Lead clinician identified for each directorate with responsibility for Quality and Safety and PMO projects	Lack of evidence to illustrate feedback and learning both within and cross directorates. Devolvement of responsibility to Directorates requires progression. Data provided to Directorates to assist decision making is not to the standard of SLR. Teams are small and it is not possible to service all directorates on TBALD. Not all directorates are	Review use of clinical audit, including attendance, output and feedback Review Directorate Structure and related governance arrangements both inter, across and external to Directorates Executive team to agree further devolvement of responsibilities. IST will continue to work with IT and Information team to develop dashboards with real time data which is consultant specific CDs or lead clinician to be identified as Director lead on PMO projects Directorate structure and corporate support to this is being re-examined. Review meeting purpose (TOR), membership and	AP AM GB AM AP ALL ALL	Jan 2013 March 2014 March 2014 Dec 2013 Dec 2013 March 2014 Nov 2013		AG = 0.5

		Designated directorate lead for all corporate departments (HR, governance, finance and patient services) Quality Committee, OMG, EMT, Health and Safety Committees all in place with Directorate membership	regularly represented at all committees therefore feedback may be limited	attendance to reflect SLM model. Provide meetings with key objectives that reflect service delivery needs	ALL	Nov 2013		
	3b Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance	Directorate Structure through which Service Line Management is delivered is in place Directorate meetings take place alternate months on TBALD with MDT attendance. Directorate Performance meetings chaired by Director of	There is a lack of Drs who aspire to be medical leaders Data provided to Directorates to assist decision making is not to the standard of SLR	Develop medical leadership program Continue to improve directorate reports	AG/AP PA	March 2014 March 2014		AG = 0.5

		Ops occur at least quarterly with some directorates having monthly reviews. Activity Review Group meets weekly to review and action RTT and other performance issues Corporate Performance Report is provided monthly and discussed at EMT and Trust Board Directorate Dashboards are provided monthly and discussed at directorate meetings and performance meetings Monitor, DoH RTT, SCG and CCG						

		targets are monitored monthly and have all been achieved in Q1 PMO projects including pre-op process/ pathway is in place with MDT and cross-directorate involvement Modernising Admin Process meetings have occurred and identified new work streams SOPs to support waiting list management have been developed Top 30 staff with long term sickness issues is examined by DOps and DHR and directorate						

		teams quarterly HR Confirm and Challenge with DOps and DHR and Directorate teams in place monthly						
	3c. Does the Board actively engage patients and staff and other key stakeholders in quality	Board, Exec and Non Exec Director links are established Involvement of Governors on large capital projects Reports to Board from MSC and Ward Managers to improve "ward to Board" communication. CEO drop in sessions Q and A at TBALD Weekly newsletter	Lack of wider engagement/involvement strategy for hard to reach groups	Patient involvement in Francis T&F groups Patient involvement/engagement workstream from Francis	ALL JS/LW	Sept 2013 Nov 2013		AG = 0.5

		Real time patient survey Friends and family survey Use of MSB to test "temperature" of organisation Cascade arrangements throughout directorates are in place CCG and governors involved in Quality Account						
4. Measurement	4a Is appropriate quality information being analysed and challenged	CPR – highlights national and local priorities & links to Monitor Risk ratings. Appropriateness of information reviewed and updated at least annually Quality Accounts	Outcomes data, particularly linking quality information with clinical audit Drilling down of information to Directorate & Consultant level is variable	Review of current outcomes data to ensure reporting of current data is appropriate and sufficient Support IT infrastructure project, ensuring that new IT portal includes access to outcomes data and facilitates links to other quality information	AP GB	October 13 November 13		A/G = 0.5

		Internal & External Audit Reviews	Linking information and reporting to patient expectations	Development of data warehouse and portal to give real-time information allowing full drill-down facility Purchase and development of Fabio system to increase patient feedback information Use of patient feedback to drive corporate quality targets	GB JS JS	April 14 April 2014 Dec 2013		
	4b Is the Board assured the of the robustness of the quality information	Internal Audits including data quality, coding, dashboards etc. External Audit review of Quality Account Challenge via Audit Committee and IGC Good practice in SIRI process – triangulation of information with complaints, RCA	Regular self-audits (i.e. Medical Records audit, fully functioning data quality audit process for by trust managers) Real-time feedback from front line clinicians (lots of information from processes, not from people Heavy reliance	Development of board links to directorates to allow regular front-line feedback from staff, allowing board members to link quality information with staff and patient feedback Updated data quality audit work-plan for self-audit, including re-audit where appropriate Development of Data warehouse and TIE functionality to enable automatic reporting of quality information, reducing	ALL GB GB	October 13 October 13	Complete	A/R = 1.0

		with actions that are re-checked	on manual collection methods – High risk of human error Re-audit processes to ensure improvements have been embedded	the need for manual intervention				
	4c Is quality information used effectively	Information in CPR meets good practice guidelines: - RAG rated - Trend analysis - Timely information Robust challenge as evidenced in Board minutes	Benchmarking data not used regularly, limiting ability to interpret Trust data Information is not available in real time, meaning it can't be used effectively as an operational tool	Identify opportunities for benchmarking against national standards / best practice Development suite of benchmarking metrics & review appropriate reporting mechanisms Development of Data warehouse and TIE functionality to enable automatic reporting of quality information, providing real time information	ALL PA GB	October 13 November 13 March 2014		A/G