Report to:	Trust Board (Public)	**Agenda item:**	**SFT4122**
Date of Meeting:	04 October 2018		

Report Title:	NHS Improvement Quality Governance Framework self-assessment 2018 – 2019			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
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Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):				

Recommendation:
To note the attached NHS Improvement Quality Governance Framework self-assessment 2018/19 which was approved by the Clinical Governance Committee at its meeting on 25 September 2018.

Executive Summary:
The self-assessment is structured around the four components of the Quality Governance Framework posing key questions about the strategy, safety culture, awareness and escalation of risk, roles and responsibilities and the use of integrated performance information. **Discussion** – are the Board: • Sufficiently aware of risks to quality? • Challenging and using quality information effectively? • If not, what improvements are required? Areas for improvement are set out in the report.

Board Assurance Framework – Strategic Priorities	
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering	☐

outstanding outcomes for a wider population	
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

SALISBURY NHS FOUNDATION TRUST

NHS Improvement Quality Governance Framework

Self-assessment 2018 - 2019

1.0 Purpose

This report sets out the Trust's self-assessment against NHS Improvement's Quality Governance Framework to satisfy itself and patients that effective arrangements are in place to continuously monitor and improve the quality of care and areas that require improvement are effectively addressed. The paper is for discussion and approval at the Clinical Governance Committee.

2.0 Background

The Quality Governance Framework (QGF) includes four key components - strategy, capabilities and culture, processes and structure, and measurement. Within each of the four components there are elements that Boards must achieve to ensure the successful delivery of the strategic objectives by:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous quality improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risk to the quality of care

This is described in the Trust's Integrated Governance Framework 2018 which is the means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of 'an outstanding experience for every patient' is well managed, cost effective and provided by a skilled and motivated workforce.

The framework is underpinned by the Accountability Framework 2018 which specifies how the performance management systems are structured and tracked to ensure delivery of the corporate objectives at every level of the organisation focusing across the breath of quality, operations, finance and workforce.

The following sections are structured around the four elements that Boards must achieve to ensure the successful delivery of the strategic objectives.

3.0 Strategy

3.1 Does quality drive the Trust's strategy?

The Board reviewed the Trust strategy in 2017 and the strategic aim remains 'an outstanding experience for every patient'. In seeking to deliver an outstanding experience the provision of high quality services for our patients is our first priority.

The Trust has six strategic objectives which reflect our commitment to delivering an outstanding experience for every patient. These are:

- Local services – our aim is to meet the needs of the local population by developing new ways of working which always put the patient at the centre of all that we do.
- Specialist services – we will provide innovative, high quality specialist care delivering outstanding outcomes to a wider population.
- Innovation – we will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of

the Trust.

- Care – we will treat our patients and their families, with care, kindness and compassion and keep them safe from avoidable harm.
- People – we will make the Trust an outstanding place to work where everyone feels valued, supported and engaged and are able to develop as individuals and as teams.
- Resources – we will make best use of our resources to achieve a financially sustainable future, securing the best outcomes with the available resources.

Delivery of the Trust strategy is underpinned by the publication of the annual report and specifically the Quality Account, which sets out the progress made in our five quality priorities in 2017/18 and the quality priorities selected for 2018/19. Progress of the priorities is monitored via an integrated performance report structured around the objectives of the organisation.

At a wider level the Trust is actively engaged in the development of the B&NES, Swindon and Wiltshire Sustainability and Transformation Partnership (STP). The STP aims to work differently across a large geography to align the skills and expertise that exists within all of our partner organisations to deliver better, higher value health and social care for our population.

Three emerging priorities for our STP in 2018/19 are:

- The wellbeing of older people
- Mental health service provision
- Improvement of outcomes and reduction in variation across the STP of people with a stroke.

3.2 Is the Board sufficiently aware of potential risks to quality?

As part of the Integrated Governance Framework the Board controls and directs the organisation and its supporting structures to identify and manage risk and ensure the successful delivery of the organisational objectives. A comprehensive Risk Management Strategy is in place. The BAF is aligned to the strategic objectives in the Trust's Strategy, Shaping the Future, which was approved by the Trust Board in December 2017. The BAF documents the Trust's six strategic priorities, progress on delivery, and the associated risks, controls, gaps and mitigation plans.

The following risks were escalated to the Board during 2017/18 which were highlighted due to their potential impact on the delivery of the Trust's strategic objectives but also the detrimental impact they could have on quality and reputation. Each risk is also presented with mitigating actions.

- Trust's financial situation
- Non elective demand above plan had a significant impact on the running of the Trust.
- Workforce – recruitment and retention.
- Implementation and risks associated with the Electronic Patient Record.
- Delays in the cancer pathway across several tumour sites. Aggregated review commenced by the Cancer Board.

The BAF and risk management processes have been subject to review by Internal Audit who concluded that 'the 2017/18 BAF is embedded within the governance structure of the Trust processes to ensure that it is continually updated (for controls, assurances, risks and gaps) and therefore operates as a 'live' document. The overall rating given was of 'Substantial Assurance'.

The review of the BAF and corporate risk register is undertaken regularly throughout the year. The assuring committees - the Clinical Governance Committee, Finance and Performance Committee and the Workforce Committee – together with the Trust Management Committee, undertake bi-monthly reviews. The assurance committees recommend inclusion of new risks on the BAF should there be sufficient concern regarding their impact on the corporate objectives. The assurance committees report into the following Trust Board any updates to the BAF and any new risks on the corporate risk register. The Audit Committee undertakes a bi-annual review of the operation of the review and updating process carried out by the Board and its committees.

The BAF is agreed annually by the Board, by undertaking a thorough review of the corporate objectives, BAF and corporate risk register at a session led by the Executive Director for Risk. At this session the Board tests the quality and robustness of the BAF and agrees the review and reporting arrangements to keep it dynamic throughout the year. The Board receives an updated BAF and Corporate Risk Register at each of its bi-monthly Board meetings held in public. The Board receives a monthly integrated performance report supported by commentary about actions being taken to address quality and performance matters. The BAF and risk register process was reviewed as part of Deloitte's well-led review and found to be fit for purpose.

4.0 Capabilities and culture

4.1 Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

The Trust Board comprising of Executive and Non-Executive Directors actively work to promote and demonstrate the values and behaviours which underpin the quality agenda. The Board's purpose is to govern and lead effectively and in so doing, build patient, public and stakeholder confidence that sustained, high quality services are delivered.

The Integrated Governance Framework clearly sets out the accountability of Directors. The Medical Director is the Trust's Responsible Officer with statutory responsibility for quality governance and is the lead for clinical effectiveness. The Director of Nursing is responsible for patient safety, patient experience, risk management, and is the Director of Infection Prevention and Control and lead for Safeguarding Adults and Children and the lead for CQC liaison and reporting.

The capabilities required to deliver good quality governance are reflected in the make-up of the Board. The individual and collective performance of the Executive Directors is reviewed twice a year by the Remuneration Committee. The performance of each Executive Director, and their development and training needs are managed by the Chief Executive against set objectives. The performance of the Chair and the Non-Executive Directors is reviewed annually by the Governors Performance Committee. The performance of each Non-Executive Director and their development and training needs are managed by the Chair. On appointment each Non-Executive Director has an induction programme. Board members receive appropriate ongoing training to ensure they can undertake their responsibilities effectively and appropriately.

At the end of 2017, the Trust commissioned Deloitte to undertake an independent well led review and reported their findings in May 2018. The review focused on the eight key lines of enquiry in the well led framework set out by NHS Improvement and the Care Quality Commission. The review found that the Board of Directors had a good blend of experience, skills and length of service. Development activity was already taking place and the review suggested further work to rebalance the focus on corporate oversight and build greater cohesion. A Board development programme continues.

It commented on a clear and concise strategic framework, but with more to do on internal engagement on the objectives to support delivery. It recognised that quality issues are a top priority for the Trust. The report recognised the challenges faced by the Trust in relation to its data quality and the quality of the information available to support decision-making. It considered the Trust recognized the importance of quality improvement and there are pockets of innovative activities across the organisation, with an ambition to roll out a holistic and standardised approach to quality improvement Trust wide.

It was recognised the Trust had made good progress with its risk management arrangements and needed to continue with embedding risk management at all levels within the organisation. It recognised some good practice in relation to raising concerns, incidents and complaints, with scope for further improving service level ownership and the sharing of learning. The review found the Trust has a proactive approach to patient engagement with good practice observed and scope for ongoing improvement. All

recommendations have been distilled into a well led action plan.

4.2 Does the Board promote a quality focused culture throughout the Trust?

The Integrated Governance Framework emphasises that the Board ensures it promotes a culture where patients are at the centre of care, staff learn from experience, and the Trust engages with patients and the public to develop future services. The Care Quality Commission inspection report identified a strong culture of reporting and learning from incidents and that there was a strong culture of being open with the Duty of Candour well understood. In the NHS staff survey 2017, the Trust was above the national average for acute Trusts for staff confidence and security in reporting unsafe clinical practice but the Trust score had decreased from 3.82 in 2016 to 3.70 in 2017.

The Board is actively engaged in service and quality improvement initiatives, some of which are led by the Director of Nursing and Medical Director. Listening to staff and involving them in improvement projects is considered crucial to sustaining improvements as seen in a variety of transformation programme work streams. In the NHS staff survey 2017, the Trust was in the top 20% of acute Trusts for staff able to contribute towards improvements at work and overall staff engagement. The Board has responded to the recommendations in the National Quality Board Learning from Deaths guidance, NHS Seven Day Services and improvements needed as an outcome of the Care Quality Commission inspection in 2015.

The Board promotes the values and behaviours - patient centred and safe, professional, responsive and friendly and professional standards for conduct and proficiency to ensure they fit with the Trust's vision of providing an outstanding experience for every patient. The values and behaviours are embedded in the staff appraisal system and recruitment process.

The Board sponsor six Clinical Governance half days a year where teams have dedicated time to work on quality improvements and actively support the annual Striving for Excellence awards which recognise staff achievements in their work to improve the quality of care. An annual Pride in Practice event was held in April 18 to celebrate nursing, midwifery and allied health professionals practice.

The 2017 NHS staff survey results showed that the Trust was above average compared to all acute Trusts in staff recommending the Trust as a place to work or receive treatment although the score had decreased since 2016. Other areas where staff scored the Trust highly were staff motivation at work and the organisation and management interest in and action on health and wellbeing.

5.0 Structures and processes

5.1 Are there clear roles and accountabilities in relation to quality governance?

The Chief Executive is the accountable officer for quality governance. Each Director is a lead for a number of Board objectives. The responsible officer for quality is the Medical Director who leads on clinical effectiveness and the Director of Nursing leads on patient safety and patient experience. The executive team have 4 shared objectives 1) Achieving reduced length of stay 2) Achieving a good CQC rating 3) Delivery against the financial recovery plan and 4) Developing as an executive team.

The Integrated Governance Framework makes it clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Deloitte well-led review said that governance at Trust Board and sub-committee level was good although work needs to be done with the Directorates. This has resulted in external review and support for Directorate Management Teams and is a priority for the new Director of Corporate Governance.

The Clinical Governance Committee's function is to provide assurance to the Board on quality by ensuring the supporting processes are embedded in Directorates and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties. The Clinical Governance Committee terms of reference and a report on the effectiveness of the Committee were presented to the Board in October 2017.

The Accountability Framework is to ensure the Trust has sufficient mechanisms in place to monitor and drive the Trust's strategic and operational plans of the Trust as a whole, and individual directorates. It describes how the Trust monitors and manages its own performance and ensures sufficient escalation triggers are in place so the Board is routinely sighted on and involved in the mitigation of key risks. The Accountability Framework aligns as closely as possible with the NHS Improvement Single Oversight Framework. One of the five themes of the Accountability Framework is the assessment of the quality of care demonstrated through the scrutiny of a range of quality information, Care Quality Commission information and 7 day service priority standards. Triggers are used to highlight issues or concerns to provide the Executive Directors with a clear line of sight on risks to quality and performance. For the purposes of oversight each Directorate is assigned a rating of red, amber or green. The overall rating for each Directorate acts as a trigger for escalation or additional support at the Executive Performance Review meetings.

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

The Accountability Framework sets out the Performance Framework which oversees the delivery of all elements of the Trust performance including service performance and quality of care, linked to the delivery of the Trust's transformational and financial plans. The Performance Framework sets out the metrics that each Directorate is held accountable for, reported in a dashboard, based on the five themes that are used as part of the overall assessment of performance at Directorate and organisational level. This includes triggers that highlight issues or concerns for escalation so the Board is routinely sighted on and involved in the mitigation of key risks. Performance ratings also flag the level of oversight required; where a Directorate has a red rating, this triggers intensive support into an area of need led by an executive director consisting of weekly meetings.

5.3 Does the Board actively engage patients, staff and other key stakeholders on quality?

The Board actively engages with patients on quality and hears a patient or staff story at each public session of the Board.

Patient experience feedback is triangulated from complaints, real-time feedback and national surveys and presented to the Board quarterly and key themes are acted upon and followed up to ensure improvement. A patient engagement plan is in place which includes involving patients in a number of projects in 2018/19.

Board Safety W alks include Non-Executive Directors to hear from all levels of staff and patients about their safety concerns with support to address them. The Chief Executive, Chairman, Medical Director and Director of Nursing undertake separate walk rounds.

The Board actively engages staff in quality. For example:

- A junior doctor and junior nurse are members of the Clinical Governance Committee.
- Staff are involved in service and quality improvement initiatives.
- Junior doctors are involved in the Health Improvement Management Programme led by senior doctors and senior managers.
- A staff 'Let's Get Engaged' programme to listen to ideas for improvement.
- Leadership development, capacity and capability within the Trust is encouraged through the NHS Leadership Academy.

The Board actively engages all other key stakeholders in quality. For example:

- Quality leads meet with commissioners to report on quality outcomes and provide assurance on key risks and mitigation.
- The Trust has a good working relationship with Healthwatch, Wiltshire who recently published an evaluation of the discharge choice policy at the Trust.
- External consultation with local voluntary organisations to decide the quality priorities for 2018/19. This work also involved Governors.
- A whole system approach is taken to transformation and pathway development which involves local

GPs, community services and social care along with the B&NES, Swindon and Wiltshire: Sustainability and Transformation Partnership.

- Working with our partners in Wiltshire Health & Care to join up care and expand the amount of care offered in the community. An early supported discharge service for stroke patients has been developed to enable patients to go home sooner and continue their rehabilitation.

6.0 Measurement

6.1 Is appropriate quality information being analysed and challenged?

At each meeting the Board reviews a report which includes metrics covering the innovation and caring strategic objectives and actions are monitored and challenged to seek assurance on progress. The Board also reviews an integrated performance report supported by commentary and improvement actions. The report includes quality, operational, workforce and financial performance to ensure no one element of the Trust's business plan can be assessed in isolation.

The Accountability Framework sets out the performance function which oversees the delivery of all elements of Trust performance throughout the year, including service performance and quality of care. The Performance Framework sets out the metrics that each Directorate is held accountable for. The metrics are taken from the Trust's Operational plan, individual directorate plans and includes all national and contractual requirements.

A dashboard which mirrors the five themes in the Single Oversight Framework is used as part of the overall assessment of performance at Directorate and organisational level. The quality of care is underpinned by the production of performance packs to provide Executive Directors at the Executive Performance Review meetings, and ultimately the Board with a clear line of sight on current performance. Directorates are expected to respond to any concerns or risks highlighted within the performance reports at the meeting. Any additional assurance is sought by way of recovery plans or increased monitoring of specific measures.

6.2 Is the Board assured of the robustness of the quality information?

The Director of Corporate Development is the Executive lead for the quality of performance data and the strategic indicator and integrated performance reports.

To ensure our data quality is able to support the assurance of overall quality of care the Trust manages a Data Quality Service which aims to ensure staff record clinical information accurately on every occasion. The Data Quality Service, in partnership with the IT training team, spend time working with staff to demonstrate best practice, as well as investigating and correcting errors and providing refresher training. The use of these techniques gives the Trust assurance that the information regarding the quality of care given is an accurate representation of performance.

The Trust went live with a new electronic patient record and data warehouse at the end of October 2016. The new system has required staff to make significant changes in practice, from the need to enter and maintain accurate information within the patient record, to training staff to better understand the patient pathway and how the various codes and status' should be applied at each point to correctly show the progress of the clinical pathway.

In 2017/18 new reporting functions were put in place, including a daily patient tracking list snapshot, an action list for monitoring the current incomplete pathway position with patient level data, a booking list to keep sight of any booking back logs, and Executive level reports to allow regular operational monitoring of progress and assurance that the Board are sighted on key risks to the delivery of the strategic objectives and mitigating actions.

The Trust was subject to an external Information Governance clinical coding audit in 2017/18. Primary and secondary diagnosis coding improved compared to the previous year whilst procedure coding declined

slightly. Improvement actions are in place. In September 2017 internal audit undertook an assurance review of data quality of two key performance indicators reported to the Board. The metrics were venous thrombo-embolism risk assessment and prophylaxis and the Friends and Family test provided reasonable assurance. All improvement actions were completed and monitored by the Audit Committee.

6.3 Is the quality information being used effectively?

The Board receives an integrated performance report on the quality of care, financial and operational and workforce performance to ensure delivery of the strategic objectives at every level of the organisation and seeks assurance on mitigating actions being taken to address risks to the quality of care.

To ensure the Board is routinely sighted on and involved in the mitigation of key risks, the BAF and Corporate Risk Register are presented bi-monthly.

Changes to service delivery or cost improvement plans that potentially risk a reduction in the quality of care are required to have a quality impact assessment and be signed off by the Medical Director and Director of Nursing before implementation.

7.0 Areas for improvement

7.1 Strategy

- Finalise the clinical quality strategy in 18/19.

7.2 Capabilities and culture

- Well-led framework - progress the well-led action plan arising from Deloitte's review.
- Engage and involve our staff in improvements through the 'Let's Get Engaged' programme
- Continue to focus on equipping staff with quality improvement skills.

7.3 Processes and Structure

- Engage with the other acute Trusts in the STP and stroke network to improve stroke performance and reduce variation.
- Continue to focus on improving data quality.
- A cluster of incidents related to the cancer pathway. Two task and finish groups were set up to review pathways and processes. Aggregated themes will be reviewed by the Clinical Risk Group and Cancer Board.
- Continue to support the embedding of the governance process within Directorate Management Teams.

7.4 Measurement

- Refine the strategic indicator metrics and integrated performance report.

8.0 Summary

This report is a self-assessment to assure the committee that the Trust has an effective quality governance framework in place to identify risks and escalate them appropriately so the Board has a clear line of sight of the risks, mitigation and areas for improvement.

9.0 Recommendation

The paper is for discussion and approval at the Clinical Governance Committee.

Claire Gorzanski, Head of Clinical Effectiveness, 10 September 2018