Quality Governance Self-Assessment

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Name of lead completing self-assessment: Robert Bolas, Interim Head of Clinical Governance. Dr Ian Reckless, Assistant Medical Director.

Responsible Directors: Professor Edward Baker, Medical Director & Mrs Elaine Strachan-Hall, Chief Nurse

Following feedback from RSM Tenon an action plan will be developed for agreement by the Trust's Board in September in preparation for phase 2 of the external assessment process.

1. Strategy

Defining and leading a strategy is a fundamental responsibility of NHS Boards.

Boards need to engage with patients, staff, and the wider community in developing their strategy, set out publicly what their strategy is, and commit to open and honest reporting against what they have intended to deliver. We would expect provider Boards to have a quality sub-committee in place to support this, and to ensure delivery of quality and continuous improvement and tracking against quality goals. Monitor will be especially interested in how ambitious, relevant, specific, robust and actionable these goals are.

1a. Does quality drive the trust's strategy?	**Trust assessment (score): *AMBER/GREEN***
1a.1. How do you define your quality priorities, and how does this link with your strategy? The Board has recently approved a Quality Strategy for the Trust, articulating the vision for the organisation with respect to clinical quality over the next five years. The strategy recognises that whilst the organisation can identify many examples of excellent care, it has not always been able to demonstrate high quality care on a consistent basis across all services and sites. The Quality Strategy, developed in consultation with a selection of leaders across the Trust, is arranged around the domains of effectiveness, experience and safety. The Quality Strategy, developed through the Quality Committee, encompasses and builds upon the goals contained within the 2010/11 and 2011/12 Quality Accounts. In this way, the aims of the Trust with respect to quality are co-ordinated and consistent – short and medium term priorities relate to longer term strategic goals. The 2011/12 Quality Account published in June 2012 states:	**Evidence provided:** • *Creating a clinically led organisation* Trust Board paper October 2009. • IBP (May 2012) identifies key strategic objectives, vision & values (Chapter 3, page 26). The first strategic objective is quality-focused – "delivering compassionate excellence." • Annual report 2011/12 sets out guiding principles, priorities, performance, market environment and financial review. • Quality Strategy identifies the vision for quality on page 1 and key goals for 2012/13 (p6 para. 6.4) • Annual Quality Account for 2011/12 reports on

Quality, effectiveness and the safety of patient care and patient experience remain at the centre of all we do at Oxford University Hospitals NHS Trust. Quality is the key focus for the Trust Board. We call it 'Delivering Compassionate Excellence'- the kind of care you would want for yourself and your family if you needed healthcare.	• Compassionate excellence vision statement • Quality Committee meets quarterly. Minutes for minutes December 2011 & March 2012. • Board Away Day paperwork re Clinical Strategies and identification of work streams x 3 presentations to Board in Committee December 2011 • Outputs from Strategy Days April and September 2011 • Board Quality reports, Patient and Public involvement strategy, Patient Panel meetings, and annual report. • Clinical Governance Committee agenda and papers. • Documents/feedback from Patient Panel and other engagement events. The 2011/2012 Quality Account was developed to include formal check of priorities against emerging strategy; (Board Strategy Day March 2012) and CQUINs ***Assessed as GREEN***
1a.2. How do you identify and use specific quality goals? Are these based on local as well as national priorities? Quality Account priorities have been developed in conjunction with: commissioners (there is significant overlap with CQUIN goals, both local and national); staff (culminating in 2011/12 in discussion at the Clinical Governance Committee away day in February 2012); and patients (priorities have been considered and informed by patient engagement events attended by Board members). Where national CQUIN targets represent particular challenges for us locally, we have chosen to highlight and focus upon those areas through inclusion as a Quality Account priority (for example, VTE risk assessment). The development of priorities also involves horizon scanning (to ensure inclusion of national priorities) and discussion within OUH to ensure Divisional ownership.	**Evidence provided:** As above and • Minutes/agendas for PCT review meetings (Schedule 3.4) • CQUIN contract agreed with NHS Oxfordshire for 2012/13 • Quality Account for 2012/2013 • Dr Foster minutes and 'at a glance's • Dr Foster Annual Report for 2010/11 (2011/2012 in development)

Quality improvement initiatives associated with CQUINS have included delivery of VTE targets, improved responsiveness to the personal needs of patients; improved outcomes and experiences of patients admitted for coronary artery bypass grafts; improved outcomes and experiences of patients in hospital with heart failure and improved outcomes and experiences of patients in hospital with pneumonia. The specific goals chosen for 2011/2012 are as described in the Quality Account and are based on both local and national priorities. Drafts of the Quality Account were considered by Board members and members of the Trust Management Executive. A number of quality measures are included within the Oxfordshire PCT contract although not all feature as specific goals within the Quality Account. These are monitored closely through Divisions and Directorates and actions taken as appropriate.	• HSMR and SHMI (updates included in Board Quality Report and Divisional Quality Reports) • Board Performance reports • New Integrated Board Performance Report includes metrics on activity, waiting times, outcomes, safety, I&E, staff experience patient experience and pay costs • Definition of CQUINs through local discussion with commissioners. CQUINS priorities for 2012/13 agreed. • Update report to Quality Committee on CQUINS • Additional detail to be included on SHMI reduction work, including coverage of specific care pathway work • Dr Foster at a glance updated • Annual Clinical Audit Report • Outcomes from National Audits/Reports • Serious Incidents Requiring Investigation (SIRIs) • Never Events Investigations related to OUH. ***Assessed as GREEN***
1a.3.How are your quality goals communicated across the trust and wider community? Publication of the Quality Account was preceded by a patient and public engagement event that helped to inform and test the proposed priorities. The Quality Account was also offered to the Oxfordshire Health Overview and Scrutiny Committee, LINKS and commissioners for comment during its preparation. Feedback from NHS Oxfordshire was received and incorporated. The Quality Account is published on both the Trust's intranet and its external internet site, and through NHS Choices. The OUH website news page is used to provide information and updates to patients, the public, staff and the wider community on all aspects of the Trust's activities. The OUH intranet provides Now@OUH which keeps staff updated on key items of news and information. Similarly, news and initiatives and communications are also made available via Trust-wide 'global' email.	**Evidence provided:** As above and: • OUH IBP (May 2012) • Quality Account 2011/12 & summary document for internal communication. • Quality Strategy for 2012 sets out quality vision & values (Sec 2 page 1) • Compassionate Excellence letter from Chief executive (July 2012) • Senior Management and staff Chief Executive face to face briefings (power point July 2012)

The Quality Account is discussed at relevant Trust committee meetings. The publication of the Quality Account and goals for 2012/13 are described in Chief Executive Briefing events held across the Trust. Consideration is being given to inclusion of an item relating to the Quality Account and current priorities in a forthcoming edition of OUH News (a bimonthly newsletter targeted mainly at staff). For the first time, a short summary of the Quality Account (purpose, look back on achievements in 2011/12 and goals for 2012/13) has been prepared and distribution channels are being considered.	• Clinical Governance Planning & Review Workshop (February 2012) • Paperwork from patient panel meetings (see 3 below) • Update report on objectives in the Quality Account to Clinical Governance Committee October 2011 • www.ouh.nhs.uk • AGM minutes ***Assessed as AMBER/GREEN***
1a.4. How do you track on going performance, and drive improvement relative to your quality goals? Specific updates on progress against Quality Account priorities are provided through the Clinical Governance Committee (a sub-committee of the Trust Management Executive where clinicians and managers from Divisions and Corporate Directorates come together to discuss quality). The Trust recognises that the format, frequency and detail of these progress reports could be improved in order to ensure that priorities are project managed and delivered more consistently. Performance is tracked through Board reports and within divisions through their regular reviews of quality as expressed in divisional quality reports. Specific quality issues are also addressed within divisions and highlighted as necessary through Divisional reports to the Clinical Governance Committee following Divisional review. The Clinical Audit Committee aims to review the outcomes of clinical audits and action plans put in place to deliver specific outcomes. The minutes of the Clinical Governance Committee are reviewed at the Quality Committee together with At A Glance documents (immediate updates provided on key items/messages/issues arising from a meeting such as Health and Safety Committee, Dr Foster Steering Group, Clinical Risk Management Committee). Divisional performance is subject to regular review by the Executive with actions being agreed. Actions will relate to range of issues, including quality impact from financial and operational performance and delivery of cost improvement programmes.	**Evidence provided:** *As above and:* • Clinical Governance Committee minutes and papers • Quality Committee papers • Report to Quality Committee • Minutes needed of discussions at CG meetings and TME on quality goals (to be included for February Clinical Governance Committee cycle, • Board reports on VTE, pressures ulcers and actions being taken • Board Quality reports include specific reference to agreed quality goals and performance against goals • Divisional Quality Reports to include specific reference to agreed quality goals and performance against goals • Quarterly reports on CQUINs performance and actions for Quality Committee • Integrated Performance Report to the Trust **Board.** • Divisional performance review meetings ***Assessed as AMBER/GREEN***

1b. Is the Board sufficiently aware of potential risks to quality?	**Trust assessment (score): *AMBER/GREEN***
1b.1. Describe how the Board monitors and understands current and future risks to quality and takes steps to address them. The Board reviews the Trust Risk Register (TRR) regularly following collation of key risks drawn from Divisional and Corporate risk registers and review by Trust Management Executive. In addition, the Audit and Finance Committee and the Quality Committee review the registers as part of their assurance functions. Risks in relation to specific areas of performance, finance, and workforce are also included within the relevant Board reports. Executive and Non-Executive Directors take part in 'Quality Walk Rounds' and discuss specific matters with staff and patients and hear about issues that concern people delivering care. Non-executives continue to be active in making sure that agreed actions are delivered, with reporting via the Quality Committee and its reports to the Board. Reports on complaints and from patient experience information also provide the Board with information on key areas of concern to patients and their families. Divisions' quality reports include details of complaints and quarterly assurance reports are presented to the Quality Committee. The Quality Committee also receives regular 'patient stories' in order to gain an additional insight into patient experience. Patient stories, typically in the form of a DVD, have previously highlighted specific issues such as apparent discontinuity along a patient pathway and challenges around the time of discharge from hospital. The Board is informed about the potential quality implications of CIPs as detailed in 1.b.2 below.	**Evidence provided:** • Board Assurance Framework (BAF) March 2012 • Trust Risk Register (TRR) March 2012 • Board agendas and papers – available via this link • Board operational performance, finance and workforce reports which include key performance indicators. • Risk Management Strategy and related procedures/toolkits • Risk Registers (divisions and Trust) • Executive walk rounds (reported locally and in the Divisional and Board quality reports) • Divisional Quality Reports • Complaints reports • Never event investigations • Serious Incidents Requiring Investigation (SIRIs)Reports • CQC Quality Risk Profile (example June 2012) • June Quality Board paper re CIPs (QC2012 23bii) • MaRS CIPs feedback report • CIPs Appendix A sample delivery ***Assessed as GREEN***
1b.2. How are clinicians involved in the development of CIPs? The Trust introduced a clinically led structure in November 2010 and the original six divisions were increased to seven with the establishment of the Musculoskeletal and Rehabilitation Services Division following integration with the Nuffield Orthopaedic Centre NHS Trust in November 2011. Each Divisional Director is a practising clinician accountable for all activities and	**Evidence provided:** • TME and Divisional Business meeting agenda and minutes • Trust Financial Plan and CIP project plans • Performance review meetings

performance within their Division. The Trust Management Executive includes the seven Divisional Directors and is the body which prepares the financial plan that includes the CIPs.
The Board recognises that Cost Improvement Programmes (CIPs) may bring with them significant risks to the quality of the care that the organisation provides.
The Trust's Clinical Management Structure ensures that all CIPs are developed with the full involvement of practising clinicians from an early stage. Clinicians are also directly involved in the delivery of CIPs. A detailed CIP development template is in use throughout the organisation which requires clinical and non-clinical managers to specifically consider a number of quality domains. These templates also form the basis upon which the Medical Director and Chief Nurse can assess and challenge proposals on behalf of the Board. The Quality Committee provides an assurance oversight to this CIP evaluation process.
Performance compact review meetings (monthly and quarterly) between the Divisional and Executive teams monitor the delivery of financial and other performance targets. Quarterly meetings are attended by the Chief Nurse and / or a member of the Medical Director's Office (usually the Medical Director) who maintain a particular focus upon clinical quality.
In addition, the Director of Clinical Services meets regularly with Divisional Directors to discuss all aspects of performance and activity.
	• Board operational performance, finance and workforce reports.
	• FOLDER available for all CIP Executive group meetings, specific projects, plans and progress reports etc. (SS)
	  • June Quality Board paper re CIPs (QC2012 23bii)
	  • MAPs CIP
	  • CIPs Appendix A sample delivery
	Assessed as GREEN

1.b.3. How have you evaluated financial and operational initiatives (e.g. CIPs and business cases) for their impact on quality and assured yourselves that minimum common standards will not be compromised? Business cases are completed using a standard template that ensures that the proposer considers clinical quality implications. Business cases are reviewed within Divisions and then through the Strategic Planning Committee at Trust level. Documentation for business cases includes full financial and benefits assessments – specific examples include Trauma Centre ("The implementation of major trauma networks delivers against the QIPP agenda. The implementation of the network will improve the quality of care received by injured patients across the region by co-locating clinical expertise and patient need and reducing the time from injury to definitive care. Associated with this, a more efficient patient pathway should deliver improvements in productivity and financial savings at a health economy level.") CIPs have been evaluated by considering SAFE criteria (suitability, acceptability, feasibility, evidence base) in relation to each project. In recent months, a more detailed CIP development template has been brought into use throughout the organisation that encourages clinical and non-clinical managers to	**Evidence provided:** • Board reports on performance with associated narrative and action plans as required. • Divisional and Directorate meetings • Trust and Divisional Risk Registers • Strategic Planning Committee documents and papers, including Business cases (Trauma Centre, 5th endoscopy Suite, Neonatal) • Business case template • CIP Delivery template • June Quality Board paper re CIPs (QC2012 23bii) • MAPs CIP • CIPs Appendix A sample delivery ***Assessed as AMBER/GREEN***

specifically consider a number of quality domains. These templates also form the basis upon which the Medical Director and Chief Nurse can assess and challenge proposals on behalf of the Board. The Quality Committee takes an assurance overview of this CIP evaluation process.	
1b.4. How is the impact of financial and operational initiatives monitored on an on-going basis? i.e. what quality indicators will be tracked as an early warning indicator? The CIP development template includes a section inviting the proposer to consider and articulate appropriate quality indicators that should be monitored on an on-going basis to assess the impact of the CIP upon performance and quality, whether anticipated or otherwise. Quality reports to the Trust Board (and also to the Clinical Governance Committee) contain a range of metrics at the level of the ward or clinical service. These metrics provide a comprehensive suite of generic indices through which the unanticipated impact (positive or negative) of initiatives may be identified. Such metrics include those addressing nurse staffing: the Trust has now implemented a new process for managing nurse staffing levels at the Churchill and John Radcliffe Hospitals. This includes a nurse staffing matrix which documents staffing levels in all inpatient areas on both sites. It assists in identifying potential risk to patient care in specific areas, thereby informing decisions made about moving staff to support specific teams and the placement of high-dependency patients. This information is updated twice daily on weekdays. The matrix also provides an audit tool which is being developed further . A review also took place at the Horton General Hospital. The nurse staff matrix is based on establishments which have been reviewed again to provide an appropriate reference point. The purpose of this is to clarify changes made and benchmark with other organisations. Nurse shifts that are vacant are identified by the electronic rostering system and those which require filling are transferred to NHS Professionals. Both actions are authorised by the relevant Matron. The electronic rostering system is monitored in respect of performance and NHS Professionals provide a detailed database of activity on a weekly basis. Board workforce reports monitor performance indicators including sickness absence and turnover which can have an impact on the quality of services. Board performance reports monitor length of stay, DTOCs and discharges: increasing lengths of stay may impact on the quality of patient care. Board discussion takes place on these issues and the steps being taken to reduce impact on quality of care: a Trust	**Evidence provided:** • Notes from CIP review meetings and individual CIP discussions with Divisions/Directorates • Divisional and Directorate meetings • Trust and Divisional Risk Registers maintained and reviewed in line with agreed policy • Quality Report Sept 2011 included full update on nurse staffing levels – updates provided each month to the Board. • Board workforce reports • CGC review of Divisional Quality reports • CIP Folder as above • Dr Foster Group minutes and papers ***Assessed as AMBER/GREEN***

operated supported discharge service is in place to enable early discharge for appropriate patients and to support their ongoing care at home. The Trust's Dr Foster Group monitors information provided by Dr Foster and ensures that actions are taken in response to specific alerts: these alerts may signify problems in the quality of a service which are then followed up by more detailed investigation.	
1b.5. What processes are in place to identify, monitor and review risks? What is the Trust process for reviewing and responding to their QRPs? The Trust Risk Management Strategy has been reviewed and updated following two recent successful NHSLA inspections. The TRR is reviewed by the Trust Management Executive (TME) and the Board and by the Quality, Audit and Finance Committees. Divisional risk registers are reviewed within Divisions each month and specific areas of change are highlighted in Divisional Quality reports. Changes in Divisional risk registers are included in the TRR in line with policy and procedure. An incident reporting procedure is in place and incidents are reviewed and actioned in line with it. Significant incidents are reported upon in Divisional Quality Reports. Quarterly Incident, Claims and Complaints reports are made to the Clinical Governance Committee to highlight trends and areas for further work. A web-based incident reporting system (Datix) is in place in the MaRS Division and is being rolled out across other Divisions and sites. OUH's Quality and Risk Profile (QRP) is monitored on each release and a report is prepared for the Quality Committee highlighting changes in it and steps that have been taken to address any deterioration in performance. The QRP report is also presented to TME.	**Evidence provided:** • QRP updates to TME and Quality Committee • TRR reports to TME, the Board, QC and AFC • Risk Management Strategy and associated procedures • Incident reporting policy and procedures • Quarterly Incident, Comments, Complaints and Claims report and minutes and papers from regular ICC meetings. • Project plan to roll out Datix initially focus on incident reporting ***Assessed as GREEN***
1b6. How is learning from incidents identified and shared to mitigate risk? Incidents are investigated/actioned according to OUH policy. Incidents are categorised according to actual harm. The Corporate Clinical Risk team checks and revises the initial grading of incidents, and reports SIRIs externally. In general, investigation of incidents takes place within the host Division, according to central guidance, although the corporate team is involved in the day-to-day management of 'red-graded' SIRIs. Updates on new incidents and completed investigations are provided to Clinical Governance Committee in monthly quality reports. Incident investigations are 'closed' and actions reviewed through the Clinical Risk Management Committee and the Health and Safety Committee. These committees and their 'at a glance' reports form a route for the sharing of experience and learning across the organisation. For some investigations, an executive summary of findings is shared more widely within the Trust (e.g. Never Events 2012).	**Evidence provided:** • 'At a Glance's from CRMC, ICC and H&S, Medicines Safety group, submitted to Clinical Governance Committee meetings and widely circulated. • Specific 'At a Glance' for review of pharmacy incidents and practice • Quarterly report on Incidents, Claims and Complaints to Clinical Governance Committee • Annual Health and Safety Report (supported by regular meetings and their papers, at a glances and updates to the Clinical Governance Committee)

Annual reports are produced on Health and Safety and on Clinical Risk. Annual reports are produced on Complaints and Infection Control and, from 2011/2012, an annual report on Information Governance. Oxfordshire–wide review of medication incidents through, for example, controlled drugs local intelligence network. 'At A Glance' summaries provide a mechanism for swift information sharing.	• Annual Clinical Risk Report (supported by regular meetings and their papers, at a glances and updates to the Clinical Governance Committee) • Minutes of Controlled drugs local intelligence network ***Assessed as GREEN***
2. Capability and Culture *The culture of an organisation, and the commitment to quality of all members of staff, is a crucial determinant of quality performance. Boards have a key role in fostering this culture through their own focus on quality issues and through bringing the knowledge and skills needed to provide an informed challenge to the organisation.*	
2a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	**Trust assessment (score): *GREEN***
2a.1. How does the Trust ensure that the Board comprises an appropriate mix of skills and capabilities in relation to delivering good quality governance? Board development is a continuous process which includes independent review of capability and effectiveness. As part of this, the Chairman commissioned (October 2011) an independent appraisal of the Board which was completed by Professor Stuart Emslie, Visiting Professor of Healthcare Governance at Loughborough University. His findings were discussed by the Board in December 2011 and have informed a revised Board Development Programme. Board non-executive membership changed considerably two years ago with a focus on putting the right skills, capabilities and experience in place. Three NEDs have clinical backgrounds, including the Chairman.	**Evidence provided:** • Board development plan • Trust self-assessment report (Away Day) • Board Governance Assurance Framework, Memorandum and Board Development Modules • Evidence of rigorous Board challenge / NED engagement on quality issues: minutes, observations etc. (a number of Board minutes both confidential and public to be provided) • Trust Board and Quality Committee reports and minutes • Work (presentations) on the development of quality governance and assurance systems (e.g. presentation to Quality Committee September 2011) • Board Governance Assurance Framework ***Assessed as GREEN***
2a.2. Is quality performance subject to rigorous Board challenge, including full NED engagement and review?	**Evidence provided:**

The Board reviews quality performance each month in several ways including as outlined below. There is challenge, review and input from non-executive and Executive members alike. Quality reports to each board meeting cover all aspects of quality, including nursing metrics and nurse staffing levels on each ward. Input and challenge from NEDs has been particularly strong in relation to patient experience, the delivery of actions arising from the safety walk round programme and the identification of accountability. The delivery of same sex accommodation standards has also been an interest of NEDs and the subject of challenge. Annual reports are presented on clinical and non-clinical risk, on complaints and on infection control matters in addition to coverage in the monthly Quality Reports. The Board considered and agreed the annual Infection Control work plan. Operational performance reports are presented to the Board which focus on service delivery – these reports have highlighted for example the impact on the quality of care of patients that can arise from increasing lengths of stay and Delayed Transfers of Care. Updates on the delivery of Action Plans agreed with the CQC are provided to the Board through review within Divisions, by the Clinical Governance Committee and by the Trust Management Executive. The Quality Committee (which has met quarterly but is shortly to increase the frequency of meetings) receives a Quality report. This is being revised to ensure that the Quality Committee (and the Board) receives the right information to allow performance to be reviewed and assured. NED and executive challenge is demonstrated in these meetings and work commissioned as a result to ensure that reports provided are fit for purpose. Quarterly reports are provided on complaints, patient experience and infection control matters. The seven Divisions provide the Clinical Governance Committee with a monthly report on all aspects of quality, including complaints, SIRIs, risks, incidents and compliance with CQC standards in accordance with an agreed template.	*Including* *As above and* • Quality reports to the Board • Annual Reports on, for example, complaints, clinical risk, infection control, safeguarding, health and safety, Dr Foster • Individual NED/ED walk rounds and reports on actions taken • NED involvement in quality account priorities • Quality Committee reports (December) ***Assessed as GREEN***
2a.3. Can you give a specific example of when the Board has had a significant impact on improving quality performance? • The Board invited a complainant and his family to attend a public Board meeting and the issues raised on shortcomings in service provision (for Parkinson's disease) were discussed. This was followed up by a report on changes being enacted within the NTSS Division as a result • Board leadership and commitment and monitoring of all aspects of infection control, through Board training, leadership, consideration of reports, monthly, quarterly and	**Evidence provided:** *Including:* • Board minutes, paper and correspondence regarding Parkinson's complaint • Quality reports to the Board including infection control updates • Quarterly reports on infection control to Quality

annually, has raised the profile considerably and resulted in significantly improved performance in relation to targets. • Board focus and questioning on points highlighted from patient experience reports (failure to respond to answerphone messages in the Specialist Surgery outpatient areas) have ensured appropriate actions are taken. The Board members question outcomes and the sharing of learning. • The Chairman is a member of the End of Life Care Group which worked during 2011/12 to improve the care and experience of patients and their families at the end of life. A particular focus was upon ensuring more effective joint working with partners across the health and social care economy.	• Annual Report and work plan for infection control as considered by the Board • Training attendance records • Documentation on cleanliness • Patient feedback • Quality Report to December 2012 Quality Committee • End of Life Care work (see below) ***Assessed as GREEN***
2b. Does the Board promote a quality-focused culture throughout the trust?	**Trust assessment (score): *AMBER/GREEN***
2b.1. Does the Trust have an organisational vision, or set of values signed off by the Board? What part does quality have in this? The Trust Board is committed to staff engagement and sees it as essential in achieving the Trust's strategic objectives and in supporting the Trust in becoming a high performing organisation. The first priority has been to review the Trust's values. A series of conversations took place with over 700 staff, patients and leaders across the organisation resulting in the articulation of the new values of Excellence, Compassion, Respect, Delivering, Learning and Improvement which were agreed by the Board in January 2012. Quality is at the centre as demonstrated by detailed feedback reports and analysis. The Board is committed to the aim of delivering excellent care with compassion. These values are being translated through an on-going process of staff engagement into a set of behaviours that will underpin: • Recruitment and selection • Communication • Appraisal and personal development • Management of performance and conduct • Recognition and reward • Leadership and management development • Patient and customer care Nursing standards have been refreshed and are being re-launched across the	**Evidence provided:** • *http://orh.oxnet.nhs.uk/DeliveringCompassionateExcellence/Pages/Default.aspx* • Paper TB201205: Delivering Compassionate Excellence • IBP Chapters 4 and 8 • TME paper on re-launch of nurse standards of care and behaviours (cards and posters) ***Assessed as AMBER/GREEN***

organisation. The Quality Strategy articulates the Trust's vision with respect to clinical quality over the next five years. It recognises that whilst the organisation can identify many examples of excellent care, it has not always been able to demonstrate high quality care on a consistent basis across all services and sites. The Quality Strategy, developed in consultation with a selection of leaders across the Trust, is arranged around the domains of effectiveness, experience and safety. The Quality Strategy encompasses and builds upon the goals contained within the 2010/11 and 2011/12 Quality Accounts. In this way, the aims of the Trust with respect to quality are co-ordinated and consistent – short and medium term priorities relate to longer term strategic goals. Following its approval, work is under way to raise the profile of the Quality Strategy within the organisation and to begin the process of implementation.	
2b.2. How do the Board ensure that they are seen as leaders for quality within the organisation? An integrated inspection programme is in place across all clinical services, in which Board members play an integral part. Clinical Monday is led by the Chief Nurse, the Nursing directorate team and Divisional nurses. Board members (Non-executive and Executive) take part in a full and regular programme of walk-rounds across all areas of the Trust. These may occur at any time of day or day of the week, and on all four sites. A report is produced after each visit and actions identified as required. Each action is identified as local or corporate and Board members challenge to ensure completion of agreed actions. Updates on issues identified and actions taken are included within the Quality Reports to the Board and Divisions' monthly quality reports to the Clinical Governance Committee. Board members, including non-executives, have attended meetings of the Patient Panel (including roundtable facilitated discussions) and ensured that feedback influences the work of the Quality Committee, the development of the Quality Account and the development of the Quality Strategy. The Clinical Governance Committee is chaired by the Medical Director and the Patient Safety Committee is chaired by the Chief Nurse. The Chairman has focused upon a number of specific quality issues, including end of life care and the reconfiguration of services for head and neck cancer. Doctors' induction is led each month by the Medical Director.	**Evidence provided:** • Quality Reports to the Board • Quality Committee agenda and papers • Reports from a Board "walk rounds" included in Quality reports with focus on actions • Clinical Governance Committee Leadership • Divisional quality reports • Chief Executive staff Briefings • Listening into Action events • Patient Panel events. ***Assessed as GREEN***
2b.3. How does the Board encourage staff empowerment on quality?	**Evidence provided:**

The NED/Executive quality walk rounds provide an opportunity for staff to discuss all manner of topics, including quality. The values engagement work involved discussions with over 700 staff and feedback from others (see also 2.b.1 for planned work). The medium term objective is to educate and develop managers to embed the philosophy of staff engagement in their own management style and behaviours ensuring that it becomes sustainable within the organisation. Success will be measured through feedback from staff, using the staff survey and other local feedback mechanisms. The refresh of the nursing standards supports engagement and empowerment with the overriding focus of the quality and safety of care for patients. A number of events within the professional groups have encouraged/empowered staff to develop their practice, share good practice and achieve quality through leadership. The Trust Management Executive has considered and endorsed the refresh and re-launch. Policies and procedures are developed through consultation with staff and staff groups – e.g. risk management, data quality. The 2011 Staff survey was made available to all staff – significantly more than the required sample of 800. The Being open policy and Raising Concerns policy (Whistleblowing) encourage the active engagement of staff in seeking quality improvements.	*As above and:* • Nursing standards • Values evidence • Training programmes (e.g. for Care Support Workers, Serious about Safety) • Rising to the challenge - a lecture series to inspire nursing and midwifery leaders (Jan 2012 Nobody's Perfect – Human Factors in Patient Safety) • Staff survey & feedback. • Being open policy. • Raising concerns policy. • Incident reporting policy. • TME paper on standards of care December 2011. • Quality Strategy. • Staff Engagement Strategy. ***Assessed as GREEN***
2b.4. How does the Trust promote a culture where the reporting of harm and error is seen as a means of learning from experience? How the Trust is assured that this is effective? Board reports include specific sections on organisational learning and actions. In addition, the Being Open policy (revised August 2011) makes explicit the need for openness. An extract follows: There is both an ethical responsibility and a duty of candour requiring health care professionals and managers to inform patients, staff, other internal departments as well as external organisations and bodies about actions which have resulted in harm. It is recognised that a culture of openness is a prerequisite to improving patient safety and the quality of health care systems. In the past there has been inconsistency and uncertainty regarding how to communicate unintended harm caused to patients, sometimes resulting in patients or carers not being aware of what has happened. Improving patient safety in a number of domains has been defined as a key goal for the OUH during the year through the Quality Account. In addition, the Trust's Quality Strategy ensures that patient safety is a core function of the organisation. The Trust has a Clinical Risk Management Committee in place to ensure that all reported incidents are coordinated and brought together, and that action plans are delivered to	**Evidence provided:** *As above and:* • Quality Reports to the Board (include SIRIs) • Divisional Quality Reports (highlight SIRIS, incidents and complaints and requirements for learning within and between Divisions) • Being Open Policy • Minutes and agendas for ICCC and At a Glances • Raising concerns policy • Workforce report to Board ***Assessed as AMBER/GREEN***

time. This Committee, attended by representatives from each Division, is an important venue in which to ensure appropriate triangulation between incidents, complaints, patient experience data, claims and Coronial inquiry. Approximately forty members of Trust staff have recently undertaken NPSA training (April and May 2012) in root cause analysis in order to ensure that the importance of openness and learning in the investigation of serious incidents within the Trust is reinforced by those who lead the investigation of such incidents. The introduction of the Datix reporting system (referred to in 2b.5 below) is due to remove the need for paper-based reporting from 1 October 2012. Improvement is needed in the quality of analysis and presentation of safety-related information to the Board and its committees and this represents an important step.	
2b.5. How does the Trust learn from incidents, complaints and feedback from patients, and feed this back to staff? Incidents, complaints and patient feedback all feature in monthly divisional quality reports which are developed and acted upon within Divisions and presented to the Clinical Governance Committee. Challenge may be provided at CGC in relation to the approach being taken in relation to specific incidents or on apparent themes emerging across incidents, complaints and feedback, or over time. In addition, the Clinical Risk Management Committee reviews investigation reports and action plans in relation to SIRIs and closes the SIRI only when actions have been completed. A specific remit of CRMC is to identify those actions that are likely to have more generalizable applicability across the organisation. Specific Trust wide reports are produced on a quarterly basis in order to ensure that incidents, complaints and feedback are examined in the overall Trust context as well as within the local context. These reports are considered both by the Clinical Governance Committee and at Board level. The Quality Committee reviews a patient story at the beginning of each meeting and agrees on the actions to be taken forward. A recent DVD produced for the Committee has been shared with the services concerned and plans put in place to make service and quality improvements. Divisions undertake and act upon many local patient surveys in addition to action plans to respond to the Annual Patient Survey. Some of these surveys are developed and conducted with the active participation of patient groups (for example, MaRS). The Trust recognises that more can be done to communicate key themes in relation to incidents, complaints and patient feedback to staff. Several initiatives have been attempted, including the production of 'At a glance' summaries of committee meetings.	**Evidence provided:** ***As above and*** • Quality Reports to the Board and Quality Committee • Divisional Quality reports highlighting actions taken in response to Complaints and patient surveys • Annual Complaints report to the Board • Quarterly Complaints reports to Quality Committee • Quarterly report on Incidents, comments and complaints to Clinical Governance Committee • CQC Action plan (e.g. DANI) • Patient story DVD and audio files (2 stories) • Patient surveys and divisional action plans ***Assessed as AMBER/GREEN***

The development of a 'Quality Matters' newsletter is under consideration. This would be for clinical staff and would aim to share experience and learning across the organisation. In relation to specific incidents that are reported, the implementation of the Datix system (being rolled out during 2012/13) is intended to permit more timely and visible feedback from local managers and the corporate clinical risk department to those who report incidents than has been the case to date with paper-based incident reporting.	
2b.6. How is quality communicated across the organisation e.g. vision, goals, performance? Trust values (Delivering compassionate excellence) have been a means of communicating objectives across the Trust. In addition, the Chief Executive holds regular briefing for leaders within the Trust on all four sites and these provided the opportunity for both general messages and very specific messages on, for example, Patient Safety Week. Importance of quality emphasised – for example in the Quality Account, Quality Strategy and Compassionate Excellence Initiative and compliance with the CQC Essential Standards of Quality and Patient Safety and NHLSA Standards. Divisional Quality reports available within Divisions to highlight specific areas of quality performance. Inspection visits introduced in May 2011 continue as part of normal business – the visits involve the executive and other Trust Directors together with members of the divisional teams. The Quality Committee and the Board receive updates on the programme of visits. These visits have taken place across all sites and at all hours of the day and night. It is recognised that improving awareness of, and access to, Divisional quality reports and corporate material relating to clinical governance matters 'at the shop floor' is an area in which further progress is required. The development of a 'Quality Matters' newsletter is under consideration. This would be for clinical staff and would aim to share experience and learning across the organisation. The launch and implementation of the Trust's Quality Strategy will be reliant upon robust communication.	**Evidence provided:** *As above and:* • CE's slides and team briefing on staff intranet • OUH Intranet with specific pages for values and delivering compassionate excellence • Inspection reports • Divisional Nurses' presentation on Inspections and Quality Assurance ***Assessed as AMBER/GREEN***
3. Processes and structures *Capability and culture will underpin the successful implementation of a quality strategy, but structures and processes make sure it happens and it is embedded throughout the organisation. Without effective processes and structures that are recognised, understood and owned by Board members and staff, it will be impossible for your Trust to successfully govern for quality.*	

3a. Are there clear roles and accountabilities in relation to quality governance?	**Trust assessment (score): *GREEN***
3a.1. Do Board members understand their ultimate accountability for quality? Board members understand their accountability for quality and each year (from 2010) the Chairman and Chief Executive have included specific statements on quality and the role, commitment and accountability of the Board for quality in the Quality Account. Board away days have included discussion on all aspects of governance including quality, both in relation to business as usual and specific items on readiness for FT. Review of BAF and supporting processes will support understanding in relation to quality governance and assurance. In more general terms, the Board has paid specific attention to reports from the Healthcare Commission, CQC and others on important quality issues (including the Francis Report, and the PHSO report Care and Compassion). The Board has used these reports to critically appraise Trust systems and to assure itself on leadership in the delivery of quality. The Serious About Standards programme in 2010/11 emphasised the importance of quality and Board members attended some of the lectures in this series**.**	**Evidence provided:** • Board meeting agenda, papers and minutes • Agenda and papers for Quality Committee, Clinical Governance Committee and supporting committees • Presentation to Board Away Day, May 2012 • Divisional report template • Organisation charts – committee structure below the Board and TME and its committee structure; CGC supporting committee structure • Action plans from Care and Compassion (e.g. – papers to Board and Quality Committee) • Circulation of Francis report to all Board members • Serious about standards programme 2010 and 2011 • http://ouh.oxnet.nhs.uk/Nursing/Pages/SeriousaboutSafetyandStandards.aspx • BAF and TRR next steps paper (Quality Committee December 2011) and action plan ***Assessed as GREEN***
3a.2. How is responsibility for delivering quality performance cascaded from "Board to ward to Board"? The Board reviewed its committee structure in late 2010 and introduced a new structure in January 2011. A new Committee, the Quality Committee, has been in place since January 2011, meeting quarterly. The frequency and timing of the meetings of the Board and its sub-committees is under review currently. The Trust Management Executive also reviewed the committee structure reporting to it and the Clinical Governance Committee, chaired by the Medical Director, has been in place since March 2011. TME has confirmed the Clinical Governance Committee's supporting committee structure covering all aspects of clinical governance, including patient safety, infection control, clinical audit, clinical risk management and health and	As above and: • Divisional Directors and others job descriptions including Divisional Nurses • Standard agendas for Divisional meetings (Divisional meetings and papers [NTSS example]) • Terms of reference for Board and TME committees • Terms of reference for Clinical Governance supporting committees • At A Glances – Dr Foster, CRMC etc. Evidence of

safety. A clear line of accountability exists from the Board to Ward and back through the Trust's seven Divisions. Divisional Directors are accountable for the delivery of all aspects of performance and quality and this is discharged through the clinical services through clinical directors and their teams. In addition, divisional nurses have a specific role in the delivery of the quality agenda and this work is supported by the matrons who are accountable to the clinical directors: support is provided by the corporate teams. Divisions have governance arrangements in place which are reported upon regularly to the Clinical Governance Committee: Governance is key to all activity within Divisions. Quality-related issues are discussed and acted upon at weekly Divisional meetings. Clinical governance is owned by the entire Division and each Directorate is accountable for governance through its Clinical Director with the Divisional Director being accountable to the Director of Clinical Services. Minutes of the Clinical Governance Committee are submitted to the Quality Committee each quarter (in draft form shortly after the meeting and approved on a quarterly batch basis) and through the Quality Committee's minutes to the Board. As identified above, the development of a 'Quality Matters' newsletter is under consideration. Some Divisions already have experience of developing and distributing a local quality newsletter. Divisional Quality Reports are prepared and reviewed in Divisions each month and presented to the Clinical Governance Committee. The template for the reports continues to develop to achieve consistency of approach and reporting. It is recognised that the systems in place for gathering data from clinical areas in order to present information to Divisional and Trust committees require further development. Work is under way to automate the collection and analysis of information from clinical areas in order to facilitate benchmarking and trend analysis. Weekly meetings are held between Director of Clinical Services and the Divisional Directors.	• Appraisal process ***Assessed as GREEN***
3a.3. Are you assured that quality receives sufficient coverage both in Board meetings and in relevant committees / sub-committees below Board level? Assurance is provided as evidenced through the Quality Committee paperwork and the Clinical Governance Committee. The Board agenda is structured with the consideration of Quality as the first section on the agenda. The Quality Committee agenda is structured to cover the key domains of quality. The Trust has recently carried out a review of information requirements and the quality of	**Evidence provided:** *As above and:* • Quality Committee paperwork (December 2011) – including Information requirements exercise and BAF and TRR review – next steps • Audit and Finance Committee review of BAF and TRR (next steps paper).

information presented to the Quality committee. An action plan was presented to the December Quality Committee for approval of a work plan to develop and further improve reporting in relation to quality over the coming months. This will in turn support and inform the process of reporting on quality issues to the Board. The Clinical Governance Committee receives regular quality reports from all Divisions.	• BAF & TRR TB paper April 2012. • Quality Committee Minutes March 2012. • Minutes of Clinical Governance Committees. • Examples of Divisional Quality Reports. ***Assessed as GREEN***
3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**Trust assessment (score): *AMBER/GREEN***
3b.1. How are quality performance issues escalated to the Board? How do subsequent Board discussions lead to action? Please give examples. Escalation is achieved through a combination of routine papers and discussion, and collation and review of risk registers. In addition, other less formal mechanisms (for example, safety walk rounds) provide Board members with alternative insights and an opportunity to cross check information presented in formal reports. Quality reports feature on each Board agenda and in addition, the Quality committee receives detailed reports on a number of aspects of quality. Quality issues have been raised with NED/EDs on safety walk rounds and points are escalated for action. Summary reports on actions taken are included in Board reports (e.g. in relation to the use of answerphones in clinical areas). Examples of quality issues escalated to the Board include: • HSMR/SHMI updates are discussed at the Board and actions are reviewed through monthly quality reports. • Infection control – detailed discussions at the Board with follow up on actions and assurance reports to Quality Committee. • Pressure ulcers – updates have been provided to the Board and Quality Committee on actions being taken to improve performance; additional resource has been provided. • Parkinson's patient attendance at Board meeting and review of Neuroscience service resulted.	**Evidence provided:** • Board reports, minutes and agendas • Care and Compassion – Ombudsman's report on ten complaints • Divisional reports and patient experience reports • Patient surveys and action plans • Patient story DVDs and audio files • Parkinson's patient experience and review of Neurosciences ***Assessed as GREEN***
3b.2. How do staff raise issues and concerns? How does the Board know that this is happening and become aware of particular issues? Staff are encouraged to raise concerns within regular team and management meetings. In addition, the Trust has a well-publicised Raising Concerns policy which allows staff to	**Evidence provided:** • Raising concerns policy and implementation plan • Workforce report highlighting any concerns raised.

raise issues through a confidential helpline, email account and postal address, HR monitor the concerns raised and the outcomes of investigations and report to the Board within the Quarterly Workforce report. Executive walk rounds provide the opportunity for staff members to raise items with Board members. Joint Staff Consultation and Negotiation Committee in place.	• Patient and staff feedback reports • Leaders' briefings, team briefing sessions and Chief Executive breakfasts • Executive walk rounds and updates through Board Quality reports and divisional quality reports • Meeting papers from JSCNC ***Assessed as GREEN***
3b.3. Do the Trusts clinical audit and internal audit functions effectively cover quality governance? Clinical audit activity is embedded within the Trust's Directorates and Divisions. Divisional representatives sit on the Trust's Clinical Audit Committee (established September 2011). The Clinical Audit Committee determines the framework of priorities within which each Directorate and Division's annual audit programme should operate. The Clinical Audit Committee reports to the Clinical Governance Committee. A primary function of the Clinical Audit Committee is to ensure that approved National Clinical Audits, audits relating to NHSLA standards, audits relating to relevant NICE standards and audits required through commissioner contracts are conducted, and that the results and improvement actions are considered and monitored through the appropriate Division(s) Information on audits and actions taken to address issues are included in the annual Quality Account. The Trust recognises that clinical audit resource, programmes and systems within Divisions and Directorates are not standardised. Whilst there are areas of good practice, there is an opportunity for the sharing of that good practice and a need to ensure that clinical audit is adequately embedded in all clinical services. Dr Foster reports and alerts provide focus for data–rich quality reporting and specific focus within clinical services.	**Evidence provided:** • Terms of reference and papers for Clinical Audit Committee • Clinical audit plans from Divisions • Internal audit reports on data quality • Data quality policy and group in place with divisional membership • Dr Foster reviews and Dr Foster Group papers and minutes. • Annual Clinical Audit Plan for 2012 sets out priorities • Annual Clinical Audit Report 2011/12 ***Assessed as AMBER/GREEN***
3b.4. Is action is routinely taken to resolve concerns resulting from audits? Full information on audits and actions taken to address issues included in Quality Account. The Clinical Audit Committee monitors outcomes and actions in relation to a subset of clinical audits. Governance groups within divisions and directorates have primary oversight over	**Evidence provided:** • Quality Accounts 10/11 and 11/12 • Clinical Audit committee meeting minutes 2012 • Clinical Governance Committee papers (pre September 2011)

progress with their local audit work and forward plans. An Annual Clinical Audit Report was received by the Quality Committee in June.	***Assessed as AMBER***
3b.5. How do performance management systems lead to improvements in quality performance? Divisions review all aspects of performance monthly within the Divisions and in performance review meetings. Performance improvements have been seen, for example, in cancer targets following agreement of a cancer action plan for Q1 and Q2 2011/12. Performance has been maintained. Performance is also reviewed routinely through TME. Performance in relation to a number of quality metrics has improved following monitoring through the Clinical Governance Committee. Areas include fracture clinic waits on the Horton site and VTE risk assessment across the Trust (which improved through 2011/12 to exceed the 90% target).	**Evidence provided:** • Board Operational performance reports • Cancer action plan • TME papers and minutes • Divisional management team meetings and papers (see NTSS) • Executive review of Divisional performance ***Assessed as GREEN***
3b.6. Does your organisation also make effective use of continuous improvement approaches? The Productive Ward programme is used to drive improvements in the care provided to patients. The service improvement team aims to deliver improvements in both the efficiency and effectiveness of services and hence to improve quality – current projects include length of stay, timely TTOs and front door flow. A number of other initiatives have adopted continuous improvement methodologies. The Trust is supportive of the Learning to make a difference project operated via the Royal College of Physicians and a number of trainees (supervised by Consultant staff) have undertaken important although small-scale projects. Examples include: • VTE risk assessment in Acute General Medicine (winner of national Junior Doctor Audit of the Year award for 2011) • Home for lunch (discharge planning) • Theatre utilisation • Waste in theatres • Medication safety in the surgical assessment unit. • Improving anti-coagulation therapy	**Evidence provided:** • *Productive Ward* documents • Reports and documents from Quality Service Improvement Team. OUH has identified trust-wide improvement strategies focused on : • Improving the reporting of pressure ulcers • Reducing category 3 & 4 pressure ulcers • Improving VTE Assessments. • Reducing HAIs (met MRSA target; exceeded Cdiff by one case) • Cardiac Outcomes in Improving Quality Programme. • Medicines to Take Home • Medicines Reconciliation

	• Mortality Reduction (The above are set out in the Quality Account for 2011/2012) There are also documented examples of local continuous improvement initiatives including: • Women's & Children's Services, e.g. discharge planning • 'Going home'. • Paediatrics- Going home - information for parents & families. • Adult Discharge Planning (Home for Lunch). • Improving services for people with Diabetes: sliding scale insulin therapy • Digital Breast Screening • Improving safety in anti-coagulation therapy ***Assessed as AMBER/GREEN***
3c. Does the Board actively engage patients, staff and other key stakeholders on quality?	**Trust assessment (score): *GREEN***
3c.1. How does the Trust engage with patients, staff and key stakeholders to define quality priorities? A number of different means are used to permit appropriate engagement with patients, staff and other key stakeholders recognising that sustained engagement can be difficult to achieve and maintain and accepting that the format should vary according to the context. Attempts are made to engage through face-to-face meetings; invitations to provide feedback on experience; and through service user groups which in some cases are run in	**Evidence provided:** • Slides, attendance list and feedback/follow up email for April 2011 event • Information and outcomes from Panel event 5 December 2011 – to discuss draft values • Divisions action plans for inpatient survey and locally organised surveys

conjunction with partner organisations – for example commissioners and in the case of children's services, the Local Authority through the Oxfordshire Hospital School. Patient and public engagement events are held at Trust level and, importantly, at the level of individual services within the Trust. Specific examples include, Trust-wide engagement events before the publication of the annual Quality Account, an active public and patient involvement group in the MaRS Division, and the YiPpEe group which provides opportunity for children and young people to become engaged in the development of children's services. Extensive public and patient engagement activity is also carried out by Oxford's Comprehensive Biomedical Research Centre (part of the Trust), including an annual open day. PCT submitted formal comment on the Quality Account and HOSC and Oxfordshire LiNKS invited to comment. Annual Public Meeting – provided an opportunity for questions and comment. Patient specific event was held on 5 December as part of the values conversations. Annual Patient surveys inform a number of actions including planning for service improvements and quality. In addition to the annual Picker survey, patient feedback is gathered through the 'Let us know your views' questionnaire and through initiatives at service level (including cardiology, trauma and stroke). Staff engagement includes the use of the annual staff survey (which the Trust provides for all staff rather than solely to the minimum permissible sample). Recent examples of staff engagement include the development of Trust values (over 700 staff members contributed) and a series of Listening into Action events across the Trust. As detailed above, clinical engagement around quality remains a challenge. Global emails and the Trust intranet represent important strands of the Trust's communication strategy but further work is required in relation to ensuring effective cascade of information within Divisions and Directorates and in developing more tailored communications (for example, a Quality Matters newsletter as described above). **T**he Trust has worked closely with the north Oxfordshire Community through firstly the Better Healthcare programme board led by NHS Oxfordshire and now through a Community Partnership Network. OUH clinicians participated in GP Commissioning day in September 2011. The Medical Director and Chief Nurse hold a monthly informal meeting with PCT governance leads, in addition to more formal contacts through contract meetings and Clinical Governance Committee meetings.	• Outcomes from patient involvement meetings, including YiPpEe • Documents from the Better Healthcare Programme Board and the Community Partnership Board • Staff Engagement paper to the Board July 2012 • Communications plan Listening into Action July 2012 • Delivering Compassionate Care Poster July 2012 ***Assessed as GREEN***
3c.2. How do the Board ensure that they are aware of the views and priorities of patients, staff and key stakeholders?	**Evidence provided:** • As above and paperwork from previous Patient

The Board receives regular reports relating to patient experience (including complaints) and these reports are discussed at the Board and at the Quality sub-committee. The Quality Committee views and discusses a patient story at the beginning of each meeting. Board members (executive and non-executive) participate fully in a series of quality walk rounds allowing them to gain first hand insights into the experiences of staff and patients, and in so doing, to triangulate information provided through formal reports. Regular meetings are held with NHS Oxfordshire to review quality matters and performance. Executive Directors from OUH attend these meetings. PCT clinical governance lead attends the meetings of the Clinical Governance Committee. The Chief Executive and other executives attend meetings of Oxfordshire's Health Overview and Scrutiny Committee. The Director of Clinical Services and the Director of Planning and Information maintain regular contact with local DGHs who are key stakeholders in the provision of specialist services. Feedback has been provided to the Trust Management Executive through the Strategic planning committee Comments are picked up from the NHS Choices website and responded to. Chief Executive meets regularly with local MPs and more frequently when specific issues arise: regular contact maintained with Banbury MP re Horton issues. Contact is also maintained through the complaints system when constituents write to their MPS**.** The Chairman and the Chief Executive attend the Health Liaison meetings which bring together key stakeholders across Oxfordshire from the health and social care networks The Annual Inpatient Survey is reviewed and action plans prepared for the individual Divisions to take forward. Regular meetings/briefings are held by Chief Executive for staff and leaders.	• Board papers and minutes – Annual complaints Report • Quality Committee papers and minutes – Quarterly Complaints reports • Complaints response letters • Clinical Governance patient experience reports • Detailed Divisional patient experience and feedback reports • Divisional Quality reports include information on complaints and patient experience • NHS Choices website (posts are responded to and passed to services for action/noting) • Specific engagement re Head and Neck services • Divisions' action plans following patient surveys • Outcomes from staff surveys • Chief Executives' briefings and slides • Feedback from meetings with local DGHs • Meetings and papers from Health Liaison meetings • Membership Strategy (Board January 2012) ***Assessed as GREEN***
3c.3. How are quality outcomes made public and accessible to staff and the community? The Board's Quality Account is published in June each year and is available on the web as well as in hard copy. It is also published on the NHS Choices website. The Quality Account includes an assessment of performance against last year's Quality Account priorities, information on overall operational performance and the results of national clinical audits. The Trust participates fully with third parties that facilitate benchmarking by patients and potential patients – including Dr Foster (Annual Hospital Guide) and the PROMs programme.	**Evidence provided:** • Quality Account 2011/2012 • Board papers including Quality Reports and, for example, performance reports • http://www.ouh.nhs.uk/news/default.aspx (highlighting information on (for example? Research initiatives, and service improvements) • Chief Executive briefings and team briefings • Community Partnership Network meetings and

The Board's quality reports are public documents available on the Trust's website and hard copies are made available on request. Operational performance reports highlight performance issues which can impact on quality, e.g. access to services and delays in transfer. Internal and external OUH websites are used as a means of communication, as is the OUH News magazine. Regular meetings/briefings are held by Chief Executive for staff and leaders. Board executive members attend and participate in public meetings of the Community Partnership Network in relation to the development of services at the Horton General Hospital and in north Oxfordshire.	documents ***Assessed as GREEN***
4. Measurement *Measurement to support quality improvement should underpin all the quality processes previously described in this guide and if the right culture is in place will become second nature to those working in your organisation. Boards should look to ensure they have the capability internally to do the work of analysis, benchmarking, presenting good, clear reports to Boards and that the capability they have is serving the functions that are most needed.*	
4a. Is appropriate quality information being analysed and challenged?	**Trust assessment (score): *AMBER/GREEN***
4a.1. What key quality information is regularly reviewed by the Board, and why? The following items are regularly reviewed by the Board • SIRIs • HSMR/SHMI • Control of infection data • Quality Walk rounds • Staff safety incidents • Slips, trips and falls • Medication incidents • Patient feedback data including key themes, % recommendations etc. • Comments and complaints (including absolute numbers, key themes, and completion %) • Nursing staffing – staffing levels and detailed metrics covering, e.g. hand washing, catheter care, slips trips and falls	**Evidence provided:** **e.g. as above and** • Board papers and minutes – Quality Report and Performance reports • Cancer Action plan • Quality Committee papers and minutes – Quarterly Complaints reports • Infection control reports • Quality Account • Dr Foster • New Integrated Board Performance Report includes metrics on activity, waiting times, outcomes, safety, I&E, staff experience patient experience and pay costs. • Examples of reports to the Clinical Governance

• Sickness absence, appraisal and turnover The operational performance report includes the following • Access targets including cancer, 18 week, outpatient etc. • Performance on 4 hour maximum wait and time to triage and treatment • Delayed transfers of care and detail on discharges • Stroke unit care • Infection control data are also included • Length of stay (including over 14 and 21 days) • Cancelled operations It is recognised that information supplied to the Board could be improved in terms of content and quality. A particular weakness concerns those data that are currently collected manually and which relate to clinical areas (rather than individual patient care episodes). Revised processes are being put in place to improve clarity on relevant data definitions and to develop automated routes of collecting and collating data and providing information back to clinical areas and to committees and the Board. It is intended that the ability to benchmark and to monitor trends over time will result.	***Assessed as GREEN***
4a.2. What do the Trust review to ensure that they satisfy quality requirements to maintain CQC registration and to meet national standards? Divisions are expected to maintain compliance with standards and to report monthly as part of their Quality Reports to the Clinical Governance Committee. Update reports on delivery of actions required following CQC reviews and revisits presented to Trust Management Executive, Trust Board and Quality Committee. Updates on the QRP are provided to the Quality Committee and the Trust Management Executive. A programme of inspections is in place to cover compliance with essential outcomes in addition to other areas. The Infection Control team have undertaken unannounced CQC-style inspections (reported to Quality Committee). Quality Committee review of PCAs with supporting evidence. Divisional reports to the Clinical Governance Committee are formatted so as to encourage staff to complete the reports with reference to CQC standards. The Trust has procured and is rolling out the Health Assure system. This allows evidence	**Evidence provided:** • Board papers and minutes • Briefings on CQC – CEO Briefings • CQC action plans Feb 2011 to date • Quality Committee papers and minutes • QRP updates • Divisional quality reports and evidence folders in support of outcomes • Inspection reports from Divisions ***Assessed as AMBER/GREEN***

to be logged against each standard and for a 'live' document to be maintained in order to demonstrate compliance and / or clearly illustrate gaps in evidence. One service has undertaken a thorough Health Assure self-assessment (trauma) and another is compiling a similar assessment (maternity).	
4a.3. What benchmarking activity does the Trust use to ensure that they compare favourably with peers? NHS Information Authority metrics on data quality are reviewed. HSMR/HMR are reviewed against both the national mean and selected peer groups through the Dr Foster system. Information is reviewed across several domains (mortality, length of stay and readmissions) across all relevant diagnostic groups, along with patient safety indicators. Benchmark data against SHA peers are also reviewed in relation to specific services – for example, stroke and heart failure services. Incident reporting rates are benchmarking via NRLS for acute trusts. Outcomes for adult cardiac surgery procedures are benchmarked through CCAD and the CQC website through submission of data routinely to CCAD. The Dr Foster Good Hospital Guide provides information on similar hospitals based on detailed data submission each September. Dr Foster reports by HRG codes are reviewed. Comparative data made available by Health Services Ombudsman. Nursing staffing levels have been benchmarked against peers. Participation in National Clinical Audits allows for benchmarking against the performance of peers. OUH is a member of the Shelford Group of teaching hospitals and thereby has access to benchmark data covering a number of key indicators. The Trust is very conscious of a need to continue to improve the quality of outcome data used for benchmarking purposes, not least to improve clinician buy-in to the metrics used, and intends to work closely with Shelford Group peers in this area.	**Evidence provided:** • Shelford Group information • Dr Foster Annual Reports and benchmarking reports by HRG group • CCAD outcome reports • NSPA reports on responses to alerts • Nursing benchmarking data • Audit Commission reports • DH Quality Indicators for aspirant FTs • Participation in National Audits (Quality Account) ***Assessed as GREEN***
4a.4 Describe the process that shows how information reviewed throughout the trust by sub-committees, divisional leads and individual service lines up to Board level as appropriate. Data are drawn from a number of sources in order to provide information to assist with the operation, quality assurance and improvement of clinical services. The main sources of data are material derived from routine data systems (for example, Cerner Millennium – previously PAS – data relating to activity and waiting times); material held and collated	**Evidence provided:** • Divisional quality reports, Clinical Governance Committee agenda and minutes, Quality Committee agenda and minutes • Safeguard reports • Datix reports (MaRS only)

primarily by corporate teams (for example, clinical risk and infection control) and material collected at service level (for example stroke indicators). Data are reviewed and quality assured close to the point of origin before they are circulated as in order to inform decision-making. This initial validation may be undertaken by clinicians and managers within a clinical service, by corporate leads, or by the Trust's business information team. A number of data items, managed by the business information team, are available for staff to view and validate through an interactive reporting system known as ORBIT. Where several data sources relate to a single issue, efforts are made to triangulate data from different sources in order to reconcile / understand differences where possible. The appropriate information is then considered, according to the venue / purpose. The Trust has developed an integrated board report in order to provide the Board with key information on quality, performance and finance in one location. Increasingly, the Trust is developing automated data collection systems and a data warehouse approach in order that the same information can be collected and validated once before being used for a variety of purposes in a number of venues. The deployment of the online Datix reporting system for incident reporting and a range of other governance issues (on-going) will produce a step change in the timelines and efficiency of data handling in these areas. This automation and integration is work in progress. Data derived from corporate sources (for example on SIRIs and infection control issues) are cross-checked with Divisions to ensure that trust-wide figures and local figures tally prior to inclusion in quality reports. Quality reports are reviewed through Divisions (Quality Reports), the Clinical Governance Committee and the minutes of the CGC are reviewed by the Quality Committee. The Trust Board receives the minutes of the Quality Committee.	***Assessed as AMBER/GREEN***
4a.5. Describe initiatives underway to improve quality information and subsequent decision-making. Internal Audit have been commissioned to undertake a review on the quality of data and the processes supporting its provision. The Director of Assurance is leading work on the information requirements for the Board and other committees. A report on this topic has been considered by the Quality Committee. Developments include: • Implementation of software to support all aspects of assurance reporting (Health Assure) with services involved in piloting (trauma and maternity). • Development of a refined dashboard for the Board with fewer key metrics	**Evidence provided:** • Quality Committee September and December • Internal Audit reports ***Assessed as AMBER/GREEN***

(integrated board reports now in use, although set to evolve via iteration) • Datix online reporting system being implemented throughout the Trust from June 2012 to March 2013 with modules for clinical risk management / incident reporting, complaints, PALS and patient experience, legal services and clinical audit. • Development of an IT system to gather information from clinical units in order to populate reports for use in Divisions, at Clinical Governance Committee and at Board level. The system will also facilitate internal benchmarking (accessible to those who enter data at clinical unit level) and easy access to trend information over time for specific metrics. Over time, information will be quality assured with consistent data definitions and should be available in near real time in order to support improved decision-making.	
4b. Is the Board assured of the robustness of the quality information?	**Trust assessment (score): *AMBER***
4b.1. How do you assure on going information accuracy, validity and comprehensiveness? Data quality framework updated and approved by the Board In September 2010. Data Quality Committee in place to cover key areas: development and implementation of data quality strategy and policy, compliance against the Audit Commission's five data quality standards, compliance with IGST, monitor all aspects of data quality and to benchmark; identify areas for improvement, and to provide assurances to the relevant Board Committee. Data used within performance reports follows validation processes which include validation by the teams delivering the services.	**Evidence provided:** Board paper September 2010 • Data Quality Committee papers and minutes • Data Quality policy • Review through Audit Commission Assurance reviews on PbR framework • Audit Committee minutes and papers ***Assessed as AMBER/RED***
4b.2. How are the Trust assured regarding coding accuracy performance? What initiatives are underway to improve coding? Work is under way to improve clinical coding – a task and finish group established to take forward a number of key areas of work including clinical engagement and oversight. The Trust's Dr Foster group engaged in a review of clinical coding as part of an HSMR reduction project and Divisions are expected to undertake regular divisional data quality audits. The Board Quality report includes updates from the coding task group and notes improvements in, for example, the coding of co-morbidities.	**Evidence provided: as above and:** • Divisional Data quality audits • Dr Foster reduction group reports • Clinical Coding procedure manual ***Assessed as GREEN***

4c. Is quality information being used effectively?	**Trust assessment (score): *AMBER/GREEN***
4c.1. Do you ensure that quality information is used to drive improvement in quality performance? Can you give examples? The Service improvement team has undertaken a project to support to implementation and continued delivery of quality indicators in ED. The project included focus on understanding of quality requirements in what were previously known as performance indicators. A detailed plan is in place (and highlighted to the Board with briefing note on the new standards). Improved performance has followed monitoring of detailed Stroke care metrics. The Trust had a poor record on VTE risk assessment. A robust system was established in 2011 in order to record both individual risk assessments and patient admissions covered by cohort arrangements electronically. Staff are able to interrogate an underlying database by date, division, directorate, service and consultant team in order to gain an instant and detailed snapshot of performance within a given service. The richness of these data has allowed services to identify appropriate opportunities for further cohorting arrangements and to performance manage services with poor performance. This process has also led to an increased focus upon data accuracy amongst clinicians as the attribution of the primary consultant, for example, has become more visible.	**Evidence provided:** • Board performance reports • Stroke Action plan (HGH and JRH) • Dr Foster Annual Reports and benchmarking reports by HRG Group. • Clinical Coding good practice guide. • Dr Foster 'At a glance' • CQUIN contract monitoring reports and action • Divisional performance reports • Monthly Divisional Clinical Governance Reports to the Clinical Governance Committee • Integrated Performance reports. • Continuous improvement initiatives as demonstrated in section 3 (Structure & Processes) ***Assessed as AMBER/GREEN***
4c.2. Do you have a systematic process for following up any issues in which you have challenged quality information? Information to be reviewed (see above) Board reports on operational performance regularly updated to take account of changes in standards/indicators and the requirements of the Board – e.g. theatre utilisation (hours used was included following NED request from Month 7) Review already underway to ensure the collection, collation and use of the right information to support decision making and assurance.	**Evidence provided:** • See above Board performance reports • Integrated Performance Report ***Assessed as AMBER/GREEN***
4c.3. Do you ensure that quality measurement is seen as mainstream business throughout the organisation, from Board level to staff delivering care? The Board includes its commitment to quality and the accuracy of information through the Chairman's statement in the Quality Account. The provision of data in the Quality Account has been audited by the Trust's External	**Evidence provided:** • Quality Account • Audit commission audit on Quality Account and data quality

Auditors.	***Assessed as AMBER/GREEN***
4c.4. Do you work with local health care information analysts who can help interpret a wide range of data, to distinguish real issues from data anomalies and identify innovative practice to support quality improvement? The Board has drawn on the expertise of its members, particularly in relation to primary care. The Director of Clinical Services has worked with an Associate non-executive director to check that the right information and data are available to support the developing clinical commissioning agenda. Other resources used to provide data and information include Picker UK Ltd, Dr Foster and Hospedia (particularly in relation to patient experience data). Solutions for Public Health were commissioned to do support work for the IBP in relation to the market assessment (Chapter 4). Dr Foster meetings to review data, alerts, 'red bells' etc. with clinician involvement and development of action plans to rectify where required. Where data quality issues are identified, we have taken these up with Dr Foster (Imperial College) in order to contribute to the improvement of metrics against which NHS services are judged. One example relates to a high perceived mortality from kidney transplantation. Dr Foster categorises lone kidney transplantation and combined kidney-pancreas transplantation together. OUH is home to the UK's largest combined kidney-pancreas transplant programme. Patients undergoing a combined transplant are at higher risk of death than those undergoing a lone kidney transplant yet this is not factored in to the expected number of deaths by Dr Foster. OUH engaged with Dr Foster and new modelling will be applied from autumn 2012.	**Evidence provided:** • IBP Chapter 4 (supporting work includes comparison of population forecasts, demographic and demand factors, and benchmarked outcome data) • Dr Foster data ***Assessed as GREEN***