Quality Governance Internal Self-Assessment

December 2012

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

Responsible Director: Professor Edward Baker, Medical Director

Trust Total Assessment Score = *3.5*

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): *GREEN* / *Score 0.0***
	Response
1a.1. How is Quality embedded in the trust's overall strategy?	The Board agreed a Quality Strategy in June 2012, based upon the three domains of patient safety, patient experience, clinical effectiveness and outcomes. The Strategy articulates the vision for the organisation with respect to clinical quality over the next five years and was developed in consultation with a selection of leaders across the Trust. The Quality Strategy, developed with the full support of 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. Quality is discussed at all monthly Performance and Clinical Governance meetings. The

	Trust has also held a quality workshop involving a cross section of staff to get feedback on their perspective on the priorities. Clinical leaders and staff from each of our services, clinical directorates and divisions are currently working with their teams to agree local quality priorities for 13/14 consistent with the quality strategy, which will inform the specific 13/14 Trust priorities included in the Annual Quality Account. These priorities are also incorporated into the quality and performance framework and reporting systems managed within the divisions, performance and governance committee structure. In many areas, quality priorities are displayed for all staff and patients to see. This will be extended to all clinical areas for 2013/14. The *Quality Matters* newsletter is a quarterly publication highlighting key themes, challenges and achievements from a quality perspective. A range of resources on the Intranet supports quality. The trust induction and appraisal programme incorporates key information related to quality and best clinical practice. The Chief Executive launched *Delivering Compassionate Excellence* in 2012 based on the core values of excellence, compassion, respect, learning, delivery and improvement. The Chief Executive also conducts bi-monthly staff briefings, which focus on recent key issues related to patient safety, experience, outcomes, effectiveness and performance
1a.2. How are safety, clinical outcomes and patient experience captured in the Trust quality Strategy and how does it drive year on year improvement?	Safety, clinical experience and outcomes are monitored at divisional operational and governance meetings. Performance against key targets and compliance with quality standards are monitored through the divisional and trust wide performance and clinical governance committee structure. The Quality Committee, a sub-committee of the Board oversees the performance of the governance structure and processes. Agreement on the annual priorities and targets for safety, experience and outcomes is reached at divisional level. The divisional teams are also developing their medium term quality visions in order to support the overarching organisational Quality Strategy. The board receives monthly and quarterly quality reports covering many aspects of patient safety, experience and outcomes. The quarterly reports provide a trend analysis for the reference period and comparison to the previous performance. An integrated performance report has also been developed, which contains arrange of measures related to performance, quality and outcomes. Each division develops quality priorities by reviewing what is relevant to their own clinical practice. All services use a range of information including, national priorities set out in the NHS Operating Framework, CQUIN outcomes, complaints, patient involvement groups, Dr Foster Intelligence, complaints and information from incident trends on *Datix* to develop their priorities for the forthcoming year. The implementation of the electronic *Datix i*ncident reporting system in 2012 has improved the efficiency, collation and analysis of information related to incidents and associated risks for clinical service units

	(CSUs) divisional teams and corporate services.
1a.3. How are specific quality goals identified and do they reflect local as well as national priorities? Do quality goals have the highest possible impact across the Trust?	The 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), and through negotiation of additional local enhancements to the CQUIN. The development of priorities also involves horizon scanning (to ensure inclusion of national priorities) and discussion within OUH to ensure Divisional ownership. 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 2011/12 are as described in the Quality Account and are based on both local and national priorities. Members of the Trust Management Executive and of the Board considered drafts of the Quality Account. A number of quality measures are included within the Oxfordshire PCT contract and are monitored through the monthly joint contract meeting. Issues relating to service performance are raised with the respective service and progress is monitored closely through the divisional and directorate teams as appropriate remedial action is implemented. The Board has been involved in a series of stakeholder events involving internal and external stakeholders. There has also been a collation and assessment of both internal and external intelligence from a variety of sources in order to inform quality priorities: NHS Operating Framework; commissioner feedback; CQUIN contract; Dr Foster reports and alerts; current risks identified on the risk register; and, data relating to reported incidents.

1a.4. How do quality goals reflect what is relevant to patient and staff?	A number of mechanisms are used to ensure quality goals reflect what is relevant to both staff and patients. These include: stakeholder events; analysis of incidents; CQUIN negotiations with commissioners; patient and staff national survey results; internal patient and staff feedback surveys; executive quality walk rounds; complaints; and, the NHS Operating Framework.
1a.5. Demonstrate that quality goals wherever possible are specific, measurable and time-bound and show how they are tracked and drive improvement. Also show how the trust-wide quality goals link directly to goals in divisions/service i.e. tailored to the specific service.	Quality goals are measured either monthly and / or quarterly. Performance and trends are tracked through the performance and governance committee structure. The individual quality goals and performance targets drive improvements because they are specific, relevant and owned by each area. Evidence demonstrates that they have reduced harm and improved patient experience and outcomes: for example, patient falls and hospital acquired pressure ulcers. There has been increased emphasis upon the identification and monitoring of quality metrics as priorities are identified for 2013/14.
1a.6. Are there clear action plans for achieving the quality goals with designated leads and timeframes?	There are a range of action plans relating to improving patient safety, experience and effectiveness and outcomes. These are monitored through monthly contract meetings with commissioners and internally through a range of meetings including the Divisional Performance meetings, Clinical Governance Committee, Infection Control Committee and Clinical Risk Management Committee, Trust Management Executive and the Trust Board. All seven divisions have an internal governance structure to identify, monitor and resolve key issues related to patient safety, experience and effectiveness. All action plans have designated leads, and timescales for completion.
1a.7. Demonstrate how quality goals are effectively communicated and well-understood across the trust and the 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* that keeps staff updated on key items of news and information. Similarly, news of initiatives and other communications are also made available via Trust-wide 'global' email. The Quality Account is discussed at relevant Trust committee meetings. The publication of the Quality Account and quality goals for 2012/13 are described in Chief Executive Briefing events held across the Trust. A short 'at a glance' summary of the Quality Account for 2011/12 was produced to raise its profile amongst staff. Quality goals are also communicated through a variety of ways including; quality workshops, quality strategy, quality posters, quality matters newsletter, quality on Intranet and staff induction / appraisal

	programme. Going forward, alignment of all quality goals with the overarching Quality Strategy will enhance knowledge and understanding.
1a.8 How does the board regularly track performance relative to quality goals?	All divisions through their regular reviews of quality monitor progress as expressed in divisional quality reports. 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 Board also monitors progress against plan. 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 (reporting to Clinical Governance Committee) reviews the outcomes of clinical audits and action plans put in place to deliver specific outcomes. The Quality Committee receives and reviews a summary report and the minutes from the Clinical Governance Committee. The summary report provides an update on key actions and issues arising from the meeting and from the work of Clinical Governance sub-committees including Dr Foster Steering Group (outcomes), Clinical Risk Management Committee, Clinical Audit Committee and Patient Safety Committee. Divisional performance is subject to regular review by the Executive with actions being agreed. Actions will relate to range of issues, including the potential impact on patient safety, experience and outcomes from financial and operational performance e.g. delivery of cost improvement programmes. The Trust Board also receives each month, as part of the quality report, updates on: complaints, PALS, safeguarding, DOLS and safeguarding, patient experience, serious incidents, Dr Foster, CAS Alerts and infection control. The Trust Board Integrated Performance Framework measures performance compared to national targets and comparable hospital clusters, In addition the Board also receives regular updates on the progress of CQUIN and Quality Account priorities, Annual Health and Safety reports, Audit committee reports, patient stories and service presentations. Monthly divisional performance compact meetings are held, organised by the Director of Finance and Procurement, and the Director of Clinical Services. Discussion of quality is firmly embedded in these meetings with attendance by a senior member of the Medical Director's Office (MDO). The key quality related issues discussed at CGC and in performance compact meetings are communicated through reports in order that discussions held in different fora are consistent and build upon one another. There is cross-representation from the MDO at these meetings.
1B. Is the Board sufficiently aware of potential risks to quality?	**Trust assessment (score): *AMBER/GREEN / Score 0.5***

	Response
1b.1. How does the board regularly assess and understand current and future risks to quality? What steps does the board take to address current and future risks?	The Board Assurance Framework and the Corporate Risk Register are formally updated on a quarterly basis. In accordance with the Risk Management Strategy, the Board has agreed that these documents will be formally presented to the Board as a minimum on a 6 monthly basis. 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 Executive 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. Divisional 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 and to provide context at the beginning of these meetings.
1b.2. Does the board regularly review quality risks in an up-to-date risk register?	The Risk Register is reviewed by the Board on a regular basis. The template through which the Quality Committee reports to the Board incorporates a risk section.
1b.3. Is the board risk register supported and fed by quality issues captured in the directorate/service risk registers?	Yes there is an escalation process that updates the Corporate Risk Register with any issues that may have a direct impact on the strategic objectives of the Trust (approved by TME in November 2012 that draws a clear link between 'floor and Board').
1b.4. Does the risk register cover potential future external risks to quality (e.g. new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks?	Yes. The Assurance Directorate has a Horizon Scanning process that highlights emerging issues and these are included in the executive Summary of the BAF & CRR document (this is reviewed and updated in line with the quarterly review process but has also been added to following discussions on emerging issues noted through other committees. For example, the last version included a note about the change in commissioning arrangements highlighted by Finance & Performance Committee).
1b.5. Is there clear evidence of action to mitigate risks to quality?	Yes. There is a requirement for a standard CIP template to be completed for each initiative, which includes a Quality Impact Assessment (QIA). The QIA provides a structured approach to assessing the potential positive or negative impact on the delivery of services and the quality of care. Where the potential impact is negative, actions to mitigate the impact and risk must be stated. The impact is then monitored by review of the KPIs that correlate to the respective quality indicator. This is reported and assessed at quarterly reviews to provide assurance that the risks and impact are being appropriately managed. The CIPs are discussed at the monthly performance meetings. The Quality Committee

	oversees the process.
1b.6. Are proposed initiatives rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment)	Yes. The Quality Impact Assessment (QIA) provides a standard structured framework to assess the potential impact on quality. This complements the business planning / business case process which also takes it into account.
1b.7 Are initiatives with significant potential to impact quality supported by a detailed assessment that could include • **'Bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (e.g. Lean)** • **Internal and external benchmarking of relevant operational efficiency and quality metrics (e.g. nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed)** • **Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints)**	All business cases, CIP programmes and Service improvements projects follow a standardised process and undergo an assessment for quality, informed by the LEAN methodology and internal and external benchmarking where appropriate. The Trust participates in the Shelford benchmarking group, which is a useful comparator group of teaching hospitals. There is a detailed quality assessment template that assesses risk on a number of quality indicators such as complaints and mortality. Indicators are monitored and reviewed quarterly as part of regular performance monitoring. As an example of QIA monitoring, a CIP programme to enhance nursing efficiency was not implemented in three wards where external benchmarks indicated potential risk.
1b.8. Are key measures of quality and early warning indicators identified for each initiative and are quality measures monitored before and after implementation? Is mitigating action taken where necessary?	The CIP development template includes a section inviting the proposer to consider and articulate appropriate quality indicators in the Quality Impact Assessment (QIA) that once implemented, are then monitored on an on-going basis to assess the impact of the CIP upon performance and quality, whether anticipated or otherwise. These are discussed at monthly and quarterly performance meetings and the Quality committee considers a quarterly report. 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 that 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. For specific quality indicators such as complaints or incidents, where a root cause analysis is undertaken, it may be possible to trace the role that specific CIPs may have played in relation to quality. For many indicators, it is only by establishing trends in the KPIs for the quality indicators, that a relationship can be established with a CIP. It is therefore necessary to review on a monthly and quarterly basis to ensure that any such associations are speedily and effectively highlighted.
1b.9 How is the board assured that initiatives have been assessed for quality?	Board workforce reports monitor performance against a standard list of key quality indicators including sickness absence and turnover that can have an impact on the quality of services. Board performance reports monitor length of stay (including DTOC) and discharges that 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. The Trust's Dr Foster Group monitors information provided by Dr Foster Intelligence 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. Dr Foster data are reported to the clinical governance committee and form part of the quality reports.
1b.10.How are clinicians involved in the development of CIP's and other initiatives and are they accepted, understood and owned by relevant clinicians and clinical directors?	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 performance within their Division. The Trust Management Executive includes the seven Divisional Directors and is the body that 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 that requires clinical and non-clinical managers to specifically consider a number of quality domains. There is a requirement for each CIP to be signed off by the Clinical Lead for the specific CIP, together with the respective Divisional Director, to provide assurance that the CIPs have been developed with the due consideration of the impact on service delivery and quality of care. These templates also form the basis upon which the Medical Director, Chief Nurse and Director of Clinical Services can assess and challenge proposals on behalf of the Board. The Quality Committee provides an assurance oversight to this CIP evaluation process. Monthly Performance Review meetings between the Divisional and Executive teams monitor the delivery of financial and other performance targets and are

	attended by a member of the Medical Director's Office (usually the Assistant Medical Director) who maintain a particular focus upon clinical quality. The Medical Director and the Chief Nurse attend quarterly performance review meetings.
1b.11. Is there an appropriate mechanism in place for capturing front-line staff concerns including a defined whistle-blower policy? Is this reporting process defined and communicated to staff and are staff prepared if necessary to blow the whistle?	Yes, The listening in action programme was launched in 2012 and has involved all staff from a variety of areas. The purpose is to set minimal expectations for behaviour. It has included a review all related HR policies, Raising concerns Policy and a review of the Appraisal and Trust induction programme. There is also an annual staff survey, staff feedback forum and PALS service available for all staff to access. The Trust also recognises that the NHS Staff Constitution underpins the core relationship it has with its staff and that delivering its five key pledges is fundamental to how it discharges its responsibility as an employer. For example, OUH's response to the changes to the NHS Staff Constitution in March 2012 regarding the introduction of a new pledge based on supporting staff in raising concerns at the earliest available opportunity, has been to review its Raising a Concern Policy and to launch a new campaign: 'If you see something, say something'. This policy clearly explains how to raise a concern by using, an e-mail address, a postal address or a confidential telephone number. All the communication comes to HR who then takes a view about how to handle the matters raised. The Trust counter fraud specialists deal with fraud issues. We have evidence that staff use the policy through emails, phone calls and letters.
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* / *Score 0.0***
	Response
2a.1. Is quality performance subject to rigorous board challenge, including full NED engagement and review? (either through participation in Audit Committee or relevant quality focused committees and sub-committees)	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. 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 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 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, chaired by a non- executive director, ensures that Board members receive 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.
2a.2. Are the capabilities required in relation to delivering good quality governance reflected in the make-up of the board?	Due consideration has been given to the balance of skills, experience and knowledge amongst Board members. In selecting Board members, the Chair and CEO have given due consideration to various qualities that are essential for the person to be effective in their Board role. There is appropriate NED representation from the public, private and voluntary sectors. Recruitment to Board posts has been in line with Equality Act 2010 and two NEDs and an Associate Non-executive Director are medically qualified. There is an appropriate balance between Board members who are new to the Board and those who have served on the Board for longer. The majority of the Board are experienced Board members, and the Chairman of the Board has demonstrable and recent track record of successfully leading a large and complex organisation. The Chairman has previous non-executive director experience and the Chairman of the Audit Committee is a Chartered Accountant with extensive financial and commercial experience. In addition, membership includes another NED who is also a Chartered Accountant with 33 years' experience.
2a.3. Are the Board members able to: • **Describe the trust's top three quality-related priorities.**	The Board describes the three top priorities for 2012/13 in the Quality Account for in the 2011/12. The three include Patient Safety- Safe Medicines, Clinical Effectiveness-Innovation and support, and Patient Experience-Improving end of life care and delivering compassionate excellence.

• **Identify well- and poor-performing services in relation to quality and actions the trust is taking to address them.** • **Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures).** • **Understand the purpose of each metric they review and be able to interpret them and draw conclusions from them.** • **Be clear about basic processes and structures of quality.** • **Feel they have the information and confidence to challenge data.** • **Be clear about when it is necessary to seek external assurances on quality e.g. how and when it will access independent advice on clinical matters**.	Members of the Board have a pretty consistent view upon those services in the Trust that provide outstanding care. By the same token, Board members are aware of those services where further development is necessary. The Trust Board uses a range of external metrics to monitor performance. These are included in performance and quality reports including the Integrated Performance Framework and PCT Commissioning contract schedule 3, part 4. These originate from the NHS Operating Framework, East Midlands Quality Dashboard for Acute Trusts and Dr Foster, Shelford Group and national audits. These are used to review performance and initiate direct action to improve performance. The Board is informed of outcomes and recommendations from Royal College Reports. NICE recommendations are managed through a central register. Lead clinicians are identified to assess the implications and required action. The Board receives regular updates on progress. The Board also initiates external and independent reviews where assurance is required to advise on further developments e.g. Clinical Audit (KPMG) and commissioning an external review of Theatres in late 2012. The Medical Director has clearly described what is expected from clinical services and divisional management teams relating to effective clinical governance arrangements. The Trust Management Executive has endorsed this description.
2a.4. Can staff give specific examples of when the board has had a significant impact on improving quality performance (e.g. must provide evidence of the board's role in leading on quality)	The Board has focused on key areas of service provision to improve the quality including increased investment in the number of obstetric consultants, improving compliance with the WHO Checklist, dignity and nutrition, reducing the incidence of MRSA and *C Difficile*, hospital acquired pressure ulcers and falls. The board has invited complainants and their families to attend public board meetings and issues raised on shortcomings in service provision were discussed. These meetings were followed up by a report on changes being enacted within the Division as a result. In relation to infection control, Board leadership and commitment in monitoring of all aspects of infection control has been evident. Through Board training, leadership and the detailed consideration of reports, the profile has risen considerably and this has been associated with significantly improved performance in relation to targets. Board focus and questioning on points highlighted from patient experience reports have ensured appropriate action has been taken. The Chairman was a member of the End of Life Care Group which worked during 2011/ 2012 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.
2a.5. Does the board conduct regular self-assessments to test its skills and capabilities and has a succession plan to ensure they are maintained?	Formal evaluations of the Board have been undertaken within the previous 12 months including: • A full independent evaluation of Board effectiveness was completed by Professor Stuart Emslie in November 2011 which has been used to inform the Board Development Programme • The SHA observed a Trust Board meeting in March 2012 • In May 2012, the Board received feedback from KPMG on Board effectiveness as part of mock exercise on historical due diligence • In April 2012, the Chairman introduced a reflective process following each Board meeting. This included feedback from a member of the public to inform this process. A number of changes/improvements in Board and Committee effectiveness have resulted from these evaluations. The Board has had independent evaluations of its effectiveness and committee structure within the last two years by a third party. These have included the following: • An external review was commissioned between May and August 2010 of governance arrangements within the Trust. Part of this included a review of Board effectiveness. This review identified the priority areas as the Trust strategy and Board Committee structure. These were addressed at Board Away day in September 2010 and appropriate actions agreed by the Board in October 2010. • In February 2011, the Board conducted a 'Capacity and Capability Assessment' that was reviewed by the South Central SHA. • As part of this assessment, the SHA observed the Board in April 2011 and provided feedback • Following this review, a revised Board Development Plan for May to October 2011 was completed • A full independent evaluation of Board effectiveness was completed by Professor Stuart Emslie in November 2011 which was further used to inform the Board Development Programme and the Board then distilled the key themes • The SHA observed Trust Board meetings in March 2012 • In May 2012, the Board received feedback from KPMG on Board effectiveness as part of mock exercise on historical due diligence • Progress against the Board Development Plan which included an action plan, based, in part, on these evaluations, was then presented to the Trust Board in June 2012. The formal evaluations conducted have included a range of evaluation methods. The Board is however, mindful that in this process, it is yet to include the views of other stakeholders such as staff and commissioners. Consideration is being given to this as identified in the action plan below. Formal evaluations of the Board have included all dimensions of effectiveness. The external evaluations

	considered the content of Board and Committee meetings. The Trust will introduce a 360-degree feedback process that will involve staff, commissioners and other key stakeholders in evaluations of the Board.at the end of 2012. The Board has considered the skills it requires to govern the organisation effectively in the future and there are demonstrable plans in place for all key Board positions
2a.6. Do board members attend training sessions covering the core elements of quality governance and continuous improvement?	The Board receives a range of training and attend development sessions and seminars including quality workshops, risk management training and Human Factors training.
2b. Does the Board promote a quality-focused culture throughout the trust?	**Trust assessment (score): *GREEN* / *Score 0.0***
	Response
2b.1. Does the board takes an active leadership role on quality and do they take a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other trusts and external organisations)	An integrated inspection programme is in place across all clinical services, in which Board members play a key part. Clinical Monday is led by the Chief Nurse, the Nursing directorate team and Divisional nurses. Senior nurse managers are encouraged to undertake patient-facing work. Board members (Non-executive and Executive) take part in a full and regular programme of quality 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 Medical Director chairs the Clinical Governance Committee and the Chief Nurse chairs the Patient Safety Committee. Development and participation in executive walk around and identifying key issues that are regularly communicated through staff briefings. Non-Executive member of the board chairs the QC, Non – Executive and Executive of the board attended the quality workshop. The board will review key national reports into service failures and/or service reviews to highlighting organisational learning for OUH. This includes lessons learnt from e.g. Review of Mid Staffordshire NHS

	Foundation Trust (Francis Report), Care Quality Commission and Monitor (e.g. Cambridge University Hospitals report from Monitor).
2b.2. Does the board regularly commit resources, time and money to the delivering of quality initiatives?	A range of business cases is submitted to the Trust Board for support and approval. This has included additional investment in consultant staff in obstetrics to improve patient experience, safety and outcomes. The Supported Hospital Discharge Service was also supported by the board in 2012, and was aimed at getting patients home when they are medically fit, thereby bridging the gap between hospital discharge and awaiting community service support
2b.3. Does the board actively engage in the delivery of quality improvement initiatives and are some initiatives led personally by board members?	The Chief Executive leads the LIA programme and the Chief Nurse leads on delivery of 'Compassionate Excellence'. The Medical Director leads on the Quality Strategy and the Director of Clinical Services is actively engaged and involved in the development of the Supported Hospital Discharge Service in collaboration medical clinicians and is the lead director for delivering the CQUIN quality improvements.
2b.4. Does the board encourage staff to become involved and participate in quality, continuous improvement training and development? Are staff aware of what the quality strategy is and can they define the trust quality priorities for the forthcoming year?	Yes, staff are actively taking a role in developing their own quality priorities for their services for 2013 / 2014 using the trust quality strategy as the framework. The quality strategy was developed during 2012 and its profile was raised through a quality workshop in October 2012. The strategy is available via the intranet and quality forms part of all agendas at division and service level. Staff are also participating in the Listening in action scheme launched in 2012. The Trust induction programme includes elements on risk management, trust values and quality. There is also a range of mandatory and statutory training programmes including human factors training. The LIA is a phased programme - the first involves committing to a new way of working, the second relates to engaging staff, the third focuses on mobilising and empowering teams to drive change and phase four encompasses embedding changes as 'the way we do things around here.'
2b.5. Do staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment)	The introduction of Datix has shown an increase in the amount of incidents reported, as the process is more accessible and efficient. The recent staff survey results show more staff feel comfortable reporting harm and errors than in previous surveys. This has been supported by the LIA programme launched in the trust in 2012.
2b.6. Are staff entrusted with delivering the quality improvement initiatives they have identified and held to account for delivery?	The trust introduced a clinically led organisation in 2010 to establish clinical leadership for clinical quality. There is agreement with each Division as to the setting of their quality priorities and monitoring of them through the clinical Governance meetings at divisional, directorate and corporate level. There is also a central prescription of what is expected from a clinical governance perspective to support the corporate goals for quality.
2b.7. How is the quality vision and goals	Quality is communicated through a number of ways including; Quarterly *Quality Matters* newsletter,

communicated across the organisation e.g. internal communications, monthly newsletter, intranet, notice boards, and regular feature articles on quality.	stakeholder events, Intranet, posters, OUH news, quality workshop, quality banners, quality priority posters, Team and Chief Executive briefings.
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): *AMBER/GREEN* / *Score 0.5***
	Response
3a.1. Is there a clear organisation structure that cascades responsibility and accountability for delivering quality performance from 'board to ward to board'? And are there specified owners in-post and are they actively fulfilling their responsibilities?	The Trust Management Executive 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 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 the matrons who are accountable to the clinical directors support this work. Support is provided by the corporate teams. Divisions have governance arrangements in place that are reported upon regularly to the Clinical Governance Committee. Quality-related issues are discussed and acted upon at weekly Divisional meetings. The entire Division owns clinical governance 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 through the Quality Committee's minutes to the Board. The Board reviews monthly performance reports covering financial, activity and quality performance data. These include key relevant national priority and regulatory indicators, including Commissioning for Quality and Innovation (CQUIN) targets with additional reports devoted to patient safety, patient experience, clinical effectiveness and outcomes. A monthly qualitative summary is supplemented by more detailed exception reports on any areas of adverse performance.

	The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection. The Board's dashboard is backed up by a cascade of more granular reports reviewed by Board sub-Committees (for example the Quality Committee), directorates and individual services, with analysis at individual practitioner level. Monthly performance meetings take place with each Division led by the Director of Finance and Procurement and attended by the Assistant Medical Director (monthly) and the Medical Director and/or Chief Nurse (quarterly). These meetings address: financial and non-financial performance measures, quality, activity and workforce. Challenges and perfrmance are discussed in detail by the Executive team and actions are agreed to mitigate emerging risks and to manage performance. An integrated performance report was introduced in July 2012. It provides the Board and Divisions with a comprehensive set of performance data covering indicators within the domains of quality, performance, activity, workforce and finance. Some core indicators stem from the NHS Operating Framework 2012/13, Outcomes Framework 2012/13 and Monitor's Compliance Framework, while others have been identified at an operational level to report on Divisional performance.
3a.2. Does each board member understand their ultimately accountable 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**.**
3a.3. Is quality a core part of the main board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions?	Yes, evidence of this through the Integrated Board report, Monthly quality report, business cases and patient stories.
3a.4. Is quality performance discussed in more detail each month by a quality focused board sub-committee with a stable and	The Quality Committee, a sub-Committee of the Board, discusses quality in depth every other month.

regular attending membership?	
3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**Trust assessment (score): *AMBER/GREEN / Score 0.5***
	Response
3b.1. How are quality performance issues escalated to the board and is the process clear and well documented?	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, quality 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 quality walk rounds and points are escalated for action. Summary reports on actions taken are included in Board reports 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. Quality and performance issues are escalated to the Board through routine reports and through the work of TME (and the outcomes of the monthly performance meetings) and the Quality Committee. These issues are well documented in the minutes of the Quality Committee and TME, and in outcome letters from the monthly performance meetings.
3b.2 Are there agreed rules determining which quality issues should be escalated and do these rules cover escalation of serious untoward incidents and complaints?	Yes, there is a clear policy for complaints and incident reporting including how issues are escalated. All incidents are recorded on DATIX and assessed by the Risk Management Team. e.g. falls, medication errors, wrong site surgery and pressure ulcers. Either the manager will contact the Risk Team direct or where there are concerns about an incident there is direct contact with the responsible manager by the Risk Team and where appropriate this is discussed with the Head of Clinical Governance and/or Assistant Medical Director for a final decision. Serious Incidents Requiring Investigation (SIRIs) are then reported to Commissioners within 48hrs of identifying the incident as a SIRI. There is clear guidance relating to reporting and escalating incidents e.g. potential harm, media interest,

	disruption to services, loss of personal data and harm to patients. The Trust approach is consistent with that recommended by the NPSA / National Commissioning Board.
3b.3. Are action plans in place to address quality performance issues, including issues arising from serious untoward incidents and complaints? **Do action plans have designated owners and time frames and are they regularly followed up at subsequent board meetings?**	There are a range of plans in place with designated leads and time frames to address key quality issues related to performance and learning from incidents and complaints. All action plans are monitored by the appropriate committee e.g. Clinical Governance Committee, Clinical Risk Management Committee, Patient Safety Committee. Trust Management Executive and the Trust Board.
3b.4. Are the lessons from quality performance issues well-documented and shared across the trust on a regular and timely basis? Are these lessons rapidly implemented and do they demonstrate best practice?	Yes, these are discussed at the monthly performance meetings and quality meetings and included in monthly Integrated Performance Report to the Trust Board. A wide range of the key performance indicators is related to patient safety, access to diagnosis and treatment, national targets as part of the schedule part 4 contract-monitoring framework. Issues identified are reported to responsible managers and clinicians and/or the appropriate committee where action is agreed and monitored including sign off of action plans.
3b.5. Is there a well-functioning clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns?	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 internal audit plan includes a programme of reviews of key indicators and responds to the identification of any risks associated with information assurance. There is clear evidence of action taken to resolve audit concerns with re-audits taken to assess performance improvement. The Board has commissioned KPMG to review clinical audit processes and outcomes (ongoing).
3b.6. Is there a continuous rolling programme of audits that measures and improves quality? Are action plans completed from audit and are re-audits undertaken to assess improvement?	There is an annual Clinical Audit Programme, approved and monitored by the Clinical Audit Committee, the priorities for which are set out in the Clinical Audit Procedure paragraphs. The Clinical Audit Programme includes Trust involvement in rolling National Clinical Audits. Completion of action plans to implement recommendations from audit concerns is taking place within divisions This is evidenced by minutes of local Divisional audit groups / committees / meetings, minutes of

	Trust Clinical Audit Committee and records on Datix. Evidence for this is strongest for National Clinical Audits and audits specified in the PCT contract.
3b.7. How do staff raise issues and concerns? How does the Board know that this is happening and become aware of particular issues?	Staff raise concerns with their immediate manager, or divisional and/or corporate committees, through the LIA programme, executive walk rounds, raising concern policy, staff feedback sessions and staff surveys.
3b.9. Is there a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels?	All divisions through their regular reviews of quality monitor progress as expressed in divisional quality reports. 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 Board, through monthly and quarterly progress reports, monitors progress against plan. 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 reviews the outcomes of clinical audits and action plans put in place to deliver specific outcomes. The Quality Committee receives and reviews a summary report and the minutes from the Clinical Governance Committee. The summary report provides an update on key actions and issues arising from the meeting and the sub-committees such as the Health and Safety Committee, Dr Foster Steering Group, Clinical Risk Management Committee. Divisional performance is subject to regular review by the Performance Committee and escalated to the Trust Management Executive and Trust Board. Actions will relate to range of issues, including the potential impact on patient safety, experience and outcomes from financial and operational performance e.g. delivery of cost improvement programmes.
3b.10. Does the organisation 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 work with clinical teams to enable them to deliver improvements in both the efficiency and effectiveness of services and hence to improve quality – recent projects have included, length of stay, timely TTOs, front door flow, Emergency theatre, 'Home for Lunch' and supported hospital discharge service. 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) • Theatre utilisation • Waste in theatres

	• Medication safety in the surgical assessment unit. • Improving anti-coagulation therapy Home for Lunch-discharge planning
3c. Does the Board actively engage patients, staff and other key stakeholders on quality?	**Trust assessment (score): *AMBER/GREEN* / *Score 0.5***
	Response
3c.1.How does the board actively engage patients? • **Is patient feedback actively solicited and made easy to give and based on validated tools?** • **Are patient views proactively sought during the design of new pathways and processes?** • **Is patient feedback reviewed on an on-going basis with summary reports reviewed regularly and intelligently by the Board?** • **Does the board use a range of approaches to bring patients into the board room?** • **Is this feedback based on validated tools?**	The Trust has developed new mechanisms for collecting patient feedback and established a programme of Executive quality walk rounds to ensure that the Trust's senior team are closely in touch with the views and experience of patients and that services are able to become more responsive to patients' views. This scheme based on the concept of "You said… We did…" and is intended to demonstrate this level of responsiveness. The Trust regularly seeks patient experience feedback through means including local patient surveys, the use of feedback forms and through its PALS service and the receipt of comments, commendations and complaints. The use of electronic feedback is being rolled out in the Trust and will provide statistically valid data and all questions will be cognitively tested. Details are reviewed within the Divisions, the Quality Committee and the Board of Directors. One regularly asked question is whether or not the hospitals would be recommended, which pre-empts the national "Friends and Family Test" due to be implemented at OUH by the end of 2012/13. Outpatient surveys by the Picker Institute in November 2011 and published in 2012. The most recent comprehensive surveys of OUH patients are inpatient and outpatient surveys undertaken by Picker in 2011 and published in 2012 by the Care Quality Commission. In 2013 all inpatients and A&E patients will be given a comment card asking whether they would recommend the ward to family and friends. The trust currently uses the 'let us know your views' leaflet however, some services also use locally designed surveys specific for their patient groups The patient panel are actively involved in the development of patient leaflet's and are often asked their views on projects like the 'Home for Lunch' discharge campaign. The learning disability partnership group are involved in overseeing the delivery of services to patients with disabilities. The Board uses a wide range of approaches to bring patients views into the board through the use of patient's stories and the showing of DVD's at the quality committee.
3c.2. How are quality outcomes made public and are they accessible regularly and include objective coverage of both good 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 that can impact on quality, e.g. access to services and delays in transfer.

bad performance?	Internal and external OUH websites are used as a means of communication, as is the OUH News magazine. Chief Executive holds regular meetings/briefings 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. 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 that 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. The Chief Executive holds regular meetings/briefings 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.
3c.3. How does the board regularly review and interrogate complaints? How does the board regularly review serious untoward incident data?	The monthly Quality report provides an update of complaints including the number of complaints per division and key themes. The board also receives quarterly and annual reports on complaints and monthly updates on new incidents and a quarterly review of themes and trends. With the introduction Datix more robust information is available. The trust became paperless on 01 October 2012 in respect of incident reporting.
3c.4. How does the board actively engage staff on quality? • **Are staff encouraged to provide feedback on an on-going basis, as well as through specific mechanisms?** • **Is staff feedback reviewed on an on-going basis with summary reports reviewed regularly and intelligently by the board?**	The Board has agreed and published a Quality Strategy and held a quality strategy workshop for eighty-five clinical leaders and managers from all divisions. All staff are encouraged to provide feedback on an on-going basis, as well as through specific mechanisms (e.g. monthly 'temperature gauge' plus annual staff survey). Staff feedback is reviewed on an on-going basis with summary reports reviewed regularly and intelligently by the board through the LIA, CEO briefings and staff surveys. Staff engagement is central to the delivery of the Trust's business plan. Members of staff, who are empowered, engaged and well-supported perform better and provide better care. The Trust routinely participates in the annual NHS Staff Survey to assess levels of staff engagement. Firstly, as a measure of overall staff engagement, informing the Trust at organisational level on what we are doing well and where to focus attention on improvement. Secondly, at a directorate and Divisional level, to assess staff experience along with other factors e.g. patient survey, complaints and complements, so that a holistic view is taken on decisions to improve quality and patient experience. Thirdly, as a way to benchmark with comparable organisations. Its importance is reinforced by the NHS Operating Framework highlighting that the survey's question regarding whether staff would recommend their hospital to patients should be

	regarded as a key indicator of quality. The Trust is a national pioneer organisation in the Listening into Action (LIA) programme 2012/13.[1] Staff commitment to quality is demonstrated and evidenced by the changes to patient safety, quality and experience that has arisen from clinical teams who have taken part in the 'Listening into Action – First Ten' scheme, piloting the LIA change and engagement methodology. The Trust has introduced a recognition scheme linked to its values, including an annual recognition ceremony, continuing opportunities to generate good ideas and greater encouragement to provide local feedback to individuals and teams. Examples include engagement with the revision of recruitment, induction and appraisal processes. Various ways are used to celebrate services including, the staff recognition scheme approved by Trust Board and launched in August 2012.
3c.5. How does the board actively engage all other key stakeholders on quality? • **Does the board receive feedback from PALS and LINks and is this considered?** • **Are GP's and community care involved in the development of care pathways?** • **Are there discussions with GP's and community care to identify potential issues and ensure overall quality along the pathway?**	IBP and annual report show stakeholder engagement plans plus evidence of commissioner, GP and other engagement messages. The External Stakeholder Engagement Plan describes the key existing and emerging stakeholders and tailored methods used for involvement. A variety of methods are used including OUH news, available in translated versions, to enable the Board and senior management to listen to the views of patients, carers, commissioners and the wider public including hard to reach groups. There is a programme of Quality Walk rounds that are undertaken by executives and NED's. These enable a further opportunity for Board Executives to directly receive feedback from patients, relatives and carers. The Integrated Business Plan includes details of stakeholder engagement in preparing the 5-year strategy. This included input from commissioners. The Board has ensured that various communication methods will be deployed to ensure that key external stakeholders understand the messages in the IBP and will ensure that all identified hard to reach groups will be specifically contacted as part of the Trust consultation programme. There have been Health and Wellbeing Board engagement and links to IBP. The Trust meets regularly with its commissioners as part of formal performance review meetings. These review meetings provide an opportunity for constructive discussion and agreement. Issues of concern, from GPs, are raised by the PCT Commissioners at the monthly contract meetings There is also a regular quality meeting between the Medical Director, Assistant Medical Director and Head of Clinical Governance and the PCT lead on Quality and GP representative. GPs also use the Datix incident reporting system in the PCT to identify service problems. There are also discussions between GPs and divisional clinical and managerial staff to resolve operational and clinical issues**.**

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3c.6. Are the board clear about Governors' involvement in quality governance?	The Board anticipates the governors taking an active interest in quality issues throughout the organisation as part of their scrutiny role over planning and priority setting. Particular working groups involving governors and focussed on specific quality issues are likely to be established as required according to prevailing priorities.
3c.7. Is Quality performance clearly communicated to commissioners to enable them to make educated decisions?	There is a comprehensive performance framework that is reviewed at the monthly contract meeting between the OUH and PCT commissioners; This is well documented in the minutes and action log of the contract meeting.
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* / *Score 0.5***
	Response
4a.1.Is the key quality information regularly reviewed by the Board? **Examples.** • **relevant national priority indicators and regulatory requirements** • **Selection metrics covering safety, clinical effectiveness and patient experience** • **Selected 'advance warning' indicators** • **Adverse event reports/ serious untoward incident reports/ patterns of complaints** • **Measures of instances of harm (e.g. Global Trigger Tool)** • **Monitor's risk ratings (with risks to**	The following items are regularly reviewed by the Trust Board • SIRIs • HSMR/SHMI • Infection control data • Executive Walk rounds • Staff safety incidents • Slips, trips and falls • Medication incidents • Patient feedback data including key themes, • Comments and complaints (including absolute numbers, key themes, and completion %) • Nurse staffing levels and detailed metrics covering, e.g. hand washing, catheter care, slips, trips and falls. 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 time from triage and treatment • Delayed transfers of care

future scores highlighted) • **Where possible/appropriate, percentage compliance to agreed best-practice pathways** • **Qualitative descriptions and commentary to back up quantitative information**	• Stroke unit care • Infection control data • Length of stay (including over 14 and 21 days) • Cancelled operations The quality report includes the following; • Complaints and PALs • Safeguarding and DOLS (Alerts) • Patient Experience and Feedback • Patient Safety and Involvement • Bereavement and Chaplaincy • Reception and Volunteer Guides • Incidents/SIRIs • CAS/NICE • Mortality
4a.2 How does the board demonstrate that the selected metrics are; • **Linked to trusts overall strategy and priorities?** • **Covers all of the trust's major focus areas?** • **Are the best available and most useful to review?**	As in-year quality priorities, consistent with the overarching quality strategy, are identified, there is an emphasis on the selection of appropriate metrics through which to demonstrate performance. Divisions are encouraged to review existing metrics (for example Dr Foster or those required PCT contracts) and assess their value in driving and monitoring quality improvement. A provisional list of quality metrics for each service in the Trust is being developed in order to engage all services in data quality issues and quality improvement work. This list is being developed in conjunction with services. The trust values information that can be widely benchmarked. This includes data provided through the East Midlands Quality Observatory (Acute Trust Dashboard) and by Dr Foster Intelligence. Work is ongoing to improve our ability to benchmark with other peer groups including the Shelford Group. , The range of metrics cover all aspects of the three key domains for patient safety, patient experience and clinical effectiveness and Outcomes e.g. reducing harm by reducing falls, pressure ulcers and improving safety of medicines., improving patient stakeholder engagement, reducing length of stay, waiting times, use of PROMs and reducing mortality.
4a.3. Describe the quality process show how information is reviewed throughout the trust by sub-committees, divisional leads and individual service lines up to Board level to	Data is 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 primarily by corporate teams (for example, clinical risk and infection control) and material collected at service level (for example stroke indicators). Data are reviewed

form a pyramid affect?	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 has developed an 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 produce a step change in the timelines and efficiency of data handling in these areas. Data derived from corporate sources (for example on SIRIs and infection control issues) are crosschecked 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
4a.4. How is quality information analysed and challenged at individual consultant level?	The Trust has developed an IT system (ORBIT) to permit the analysis of some data points relating to individual clinical episodes from Trust level, through Division, Directorate, Service and Consultant. Data points include VTE risk assessment performance, mean length of stay, and crude mortality. The system is interactive and Consultants have access to information at patient level to inform engagement in data quality. Consultants are encouraged to access the ORBIT system. In addition, the Trust will be using clinician level Dr Foster reports to facilitate appraisal. Over 2013, further bespoke metrics will be developed for individual services.
4a.5. How is the board dashboard reviewed and updated for quality information to maximise its effectiveness?	Quality reporting as part of the Integrated Board Report (IBR) is being developed. A number of measures from a suite of metrics used within the Trust at service level and more generally will be selected for inclusion in the IBR according to Trust Quality priorities in-year, and the overall quality strategy.
4a.6 How does the board address areas lacking useful metrics? Does the board commit time and resources to developing new metrics?	The Board has driven the development of a data warehouse in order to collect quality data gathered from clinical environments in one place. Once there, this will permit contemporary reporting of quality information and appropriate benchmarking and trend analysis. The data warehouse is also essential in order to achieve integrated reporting. There has been a review of external metrics available to the Board including Dr Foster and the East Midlands Quality Dashboard for Acute Trusts. These inform the Boards approach to developing performance metrics and identifies where action is required as well as providing assurance. There has also been the development of a ward to Board project to develop a cohort of common metrics which form the basis of the divisional quality reports, submitted to the Clinical Governance Committee and

	the Trust Board. This provides improved analysis and review of quality performance.
4a.7. 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 is 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. East Midlands Quality Dashboard 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 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. There is also a review of the outcomes from the National surveys for patients and staff.
4a.8. Describe initiatives underway to improve quality information and subsequent decision-making.	Internal Audit has been commissioned to undertake a review on the quality of data and the processes supporting its provision. The implementation of software to support all aspects of assurance reporting (Health Assure) will support services and the Trust in the gathering of quality data. Development of a refined dashboard for the Board with fewer key metrics (integrated board reports now in use, although set to evolve via iteration) Datix online reporting system was implemented throughout the Trust in Oct 2012. with modules for clinical risk management / incident reporting, complaints, PALS and patient experience, legal services and clinical audit.
4b. Is the Board assured of the robustness of the quality information?	**Trust assessment (score): *AMBER/GREEN / Score 0.5***
	Response

4b.1 How is the board assured that on-going information is accurate, valid and comprehensive?	The board has established a data quality group to test the robust of the information. Heath Assure has created a mechanism for the challenge of quality information. The Data Quality Committee covers 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 that include validation by the teams delivering the services.
4b.2 Does each directorate and service have a well-documented, well-functioning process for clinical governance that assures the board of the quality of its data?	Essential prescription, and monthly quality reports, IPR, Finance and performance committee
4b.3 Is the clinical audit programme driven by national audits with processes for initiating additional audits as a result of identification of local risks?	Drivers for the Clinical Audit programme are clearly outlined in the Clinical Audit Procedure paragraphs 46 – 49. Initiation of audits is outlined in the Clinical Audit procedure paragraphs 56 and 72 – 74 Development of the Clinical Audit Programme 2013/14 is being initiated with Divisions / Directorates using a template that links non-mandatory clinical audit projects to aspects of clinical practice where a risk or need for assurance has been identified
4b.4 Is there clear evidence of action to resolve audit concerns and are action plans completed from audit, subject to regular follow-up reviews and signed off by owners?	Actions to resolve audit concerns are being taken within divisions, evidenced by minutes of local Divisional audit groups/committees / meetings. Also minutes of Trust Clinical Audit Committee (limited assurance only).
4b.5 Demonstrate how re-audits are undertaken to assess performance improvement in areas?	Re-audit is clearly outlined in the Clinical Audit Procedure paragraphs 99 - 100. Re-audit follows same process as new clinical audit paragraphs 99- 100 Datix will be able to demonstrate that re-audits have been registered Audit report template includes trend analysis on previous audits.
4b.6. How are the Trust assured regarding coding accuracy performance? What initiatives are underway to improve coding?	Meetings occur in most Directorates between coders and clinicians and Divisions are required to submit actions plans to strengthen documentation and coding in their areas. Dr Foster alerts – notes are reviewed with consultants and coders together to identify issues related to documentation / coding. Issues are fed back to clinicians and coders where relevant • 2 x HSMR (hospital standardised mortality ratio) audit projects for 2010-11 and 2011-12 involved reviewing 100's of sets of notes with clinicians and coders to identify missed Charlson Index co-

	morbidities. When identified notes were re-coded. Project reports with Divisional performance circulated for learning / improvements. • Various proformas in use / development to assist collection of appropriate coding • Charlson Index co-morbidities section added to Gen Med post take ward round proforma • Charlson Index co-morbidities being built into documentation for oncology and clinical haematology service (IT system) • Charlson Index co-morbidities review requested as part of standardised mortality review process • Clinical coding sessions at medical induction and ad hoc governance / Directorate and CSU level meetings Clinical Coding Good Practice Guide written in 2012 has recommendations that Directorates have been required to implement:
4c. Is quality information being used effectively?	**Trust assessment (score): *AMBER/GREEN / Score 0.5***
	Response
4c.1. What benchmarking activity does the Trust use to ensure that they compare favourably with peers?	Dr Foster Intelligence, East Midlands quality dashboard, SHA peer groups, NPSA 6 monthly analysis of incidents, National patient and staff survey outcomes, Shelford Group and National Clinical Audits,
4c.2. Are quality reports clearly displayed and consistent? Is the information compared with; target levels of performance in conjunction with an R/A/G rating, historic based on own performance and external benchmarks?	Yes, The trust uses a number of reports. • The Trust has piloted a standardised quality report in December 2012 called 'Ward to Board' which provides a greater level of detail of data and analysis. This format will be implemented across all seven divisions by March 2013. • The Trust Board monthly Quality Report provides progress against quality targets. The quarterly report assesses performance against previous quarters and the previous year to identify trends. • An integrated performance report (IPR) including quality measures is rag rated against national benchmarks and targeted levels of performance. For external comparison the Board also receives analysis of: • Contract monitoring reports from PCT Commissioners. • The East Midlands quality dashboard. • Dr Foster Intelligence.

4c.3. Is the quality information being used the most recent and relevant?	Yes, The Board receives monthly quality report and an Integrated Performance Report. These contain the most recent data e.g. data collection point ending 5 weeks previous. Directors, senior clinicians and managers can also access the trust 'Orbit' information data warehouse providing up to date data extracted from the electronic patient record (EPR). Orbit is accessible to staff at management level through the Intranet. There are a range of performance measures identified annually by the PCT and commissioners. Quality information provided by services is based on both national and local quality priorities based on a needs analysis. The Datix system provides services with up to date information relating to incidents.
4c.4. Is the Trust able to demonstrate how reviewing the information has resulted in actions which have successfully improved quality performance?	The trust has been able to review information for example Dr foster alerts to drive and lead to successful improvements in quality performance. For example; • Reduction in readmission rates following primary CAGB (coronary artery graft bypass) surgery • Reduction in LOS following cardiac pacemaker insertion • Medicines reconciliation within 24 hours of admission (75% of time) Q3 • Improving speed at which patients received drugs to take home by use have been speeded up by the application of lean processes and roll out of iPad near to patient ordering directly into the dispensary. • Use of technology ('mHealth') to assist pregnant women in managing gestational diabetes from their homes with virtual help from specialist obstetric team. Currently ahead of target and due to finish recruiting (50 patients) by the end of next week. The software is working well and has fully integrated into the clinical service. The Board also focused on key areas of quality in 2012 relating to falls, pressure ulcers and infection, which reduced the incidence compared to previous years.
4c.5 Is quality data for the highest priorities metrics available on demand?	Yes, Orbit is the trusts information data warehouse providing up to date data extracted from the electronic patient record (EPR). Orbit is accessible to staff at management level through the Intranet. Need words here
4c.6. Is all information used humanised and personalised where possible, for example deaths are shown as an absolute number, not embedded in a mortality rate?	Yes, the lead for PALS produces a monthly figure for patients who die in house excluding palliative care patients.
4c.7. Do you have a systematic process for following up any issues in which you have challenged quality information?	Yes, any challenge to quality information is managed through the various committee structures and is cross-referenced through the division. .