Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 14 May 2014

TB2014.61

Title	**Monitor Quality Governance Framework**

Status	For discussion and decision
History	Previous self-assessments against Monitor's Quality Governance Framework have been considered by Trust Board.

Board Lead(s)	**Dr Tony Berendt, Interim Medical Director**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. Aspirant Trusts must achieve a score of 3.5 or less against the Monitor Quality Governance framework to proceed with an application for Foundation Trust status.

2. As per the Monitor guidance for aspirant Foundation trusts, a number of self and independent assessments have been performed against the Quality Governance Framework. The last independent assessment of the OUH position against the QGF was conducted by RSM Tenon in autumn of 2012. Since that time, improvement actions have been undertaken in order to improve the Trust's position.

3. It is estimated that the Trust's position has improved from 3.0 to 2.0 over the last 12 months. Much detailed work has been undertaken. A number of larger work programmes have also made a major contribution – notably, peer review and risk summits. KPMG is about to undertake an evaluation of this latest self-assessment.

4. **Recommendation**

   Trust Board is invited to comment on the self-assessment attached as appendix 1 and, subject to any recommended changes, adopt it as the Trust position. In addition, Trust Board is invited to take a position on the need for, and timing of, further external audit review.

Progress against the Quality Governance Framework

1. Purpose

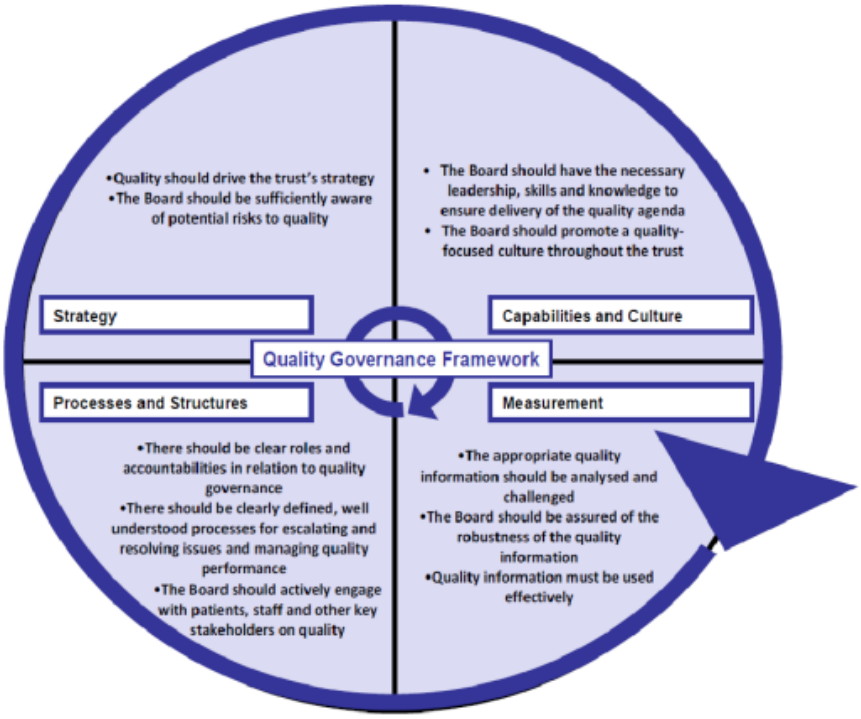
1.1. To provide an update on the Trust's estimated position with respect to the Monitor Quality Governance Framework (QGF).

2. Background

2.1. Monitor is the regulator of NHS Foundation Trusts and considers NHS Trusts for authorisation following referral from the Secretary of State.

2.2. A key element in Monitor's Assessment of readiness is a Trust's position in relation to Monitor's QGF. Figure 1 below provides further information about the domains of the QGF.

Figure 1: The Quality Governance Framework



2.3. Aspirant Trusts must achieve a score of 3.5 or less to proceed with an application for Foundation Trust status.

2.4. The Monitor QGF is intended as an iterative, living document. Following authorisation, many organisations continue to intermittently self-assess against the framework to provide assurance that governance arrangements are contemporary and fit for purpose.

2.5. As per the Monitor guidance for aspirant Foundation trusts, a number of self and independent assessments have been performed against the Quality Governance Framework.

2.6. The last independent assessment of the OUH position against the QGF was conducted by RSM Tenon in autumn of 2012. Since that time, improvement actions have been undertaken in order to improve the Trust's position.

2.7. Each domain is allocated a score based on the definitions outlined in Table 1 below:

Table 1

Score	Descriptor	Evidence Test
0	Meets or Exceeds expectations.	Many elements of good practice and no major omissions
0.5	Partially meets expectations, but are confident in management's capacity to deliver in a reasonable timeframe.	Some elements of good practice, no major omissions, and robust action plans in place to address perceived shortfalls, a proven track record of delivery
1.0	Partially meets expectations, but some concerns regarding capacity to deliver in a reasonable timeframe.	Some elements of good practice, no major omissions, action plans in place to address perceived shortfalls are in the early stage of development with limited evidence of a record of delivery
4.0	Does not meet expectations	Major omission in quality governance identified. Significant volume of action plans required and concerns about management capacity to deliver.

3. Self-assessed Current Position

3.1. Table 2 overleaf illustrates the estimated current position of OUH against each of the four key domains of the QGF, along with the outcomes of self-assessment in July 2012 and most recently April 2013.

3.2. It is estimated that the Trust's position has improved from 3.0 to 2.0 over the last 12 months. Much detailed work has been undertaken. In addition, a number of major work programmes have also made a major contribution – notably, peer review and risk summits.

3.3. It is likely that risk / gaps have reduced in respect of sub-domains 3a and 3c (as highlighted in green in table 2) over the last year as a result of the following steps:

3.3.1. Increased clarity around lead director for quality

3.3.2. Improved cross flow of information between CGC and performance meetings

3.3.3. Improved governance arrangements in the divisions

3.3.4. Improved standard of risk registers

3.3.5. Patient experience strategy

3.3.6. Implementation of FFT

3.3.7. Enhanced profile and evidence of use of patient stories

3.3.8. Risk Summit and Peer Review programmes

3.3.9. Clear involvement of stakeholders risk summit and peer review work

4. **Future**

4.1. An internal audit review of Quality Governance arrangements by KPMG has been initiated, which is currently in progress. This review has been conducted in two parts – Divisional & Directorate arrangements (complete – *significant assurance*), and Organisational arrangements (ongoing).In addition, the attached self-assessment is undergoing validation via the KPMG internal audit programme.

4.2. It is anticipated that it will be possible for the Board to modify the headline self-assessment scores to reflect CQC findings when the Board considers this paper.

5. Recommendation

5.1. Trust Board is invited to comment on the self-assessment attached as appendix 1 and, subject to any recommended changes, adopt it as the Trust position.

5.2. Trust Board is invited to take a position on the need for, and timing of, further external audit review.

Dr Tony Berendt
Interim Medical Director

Annette Anderson
Head of Clinical Governance

Dr Ian Reckless
Acting Deputy Medical Director

May 2014

Table 2

	Jul 2012 OUH Self-assessment	Oct 2012 RSM Tenon Score	Dec 2012 OUH Self-assessment	April 2013 OUH Self-assessment	May 2014 OUH Draft Self-assessment (pending Board sign-off)
Strategy					
1a. Does quality drive the trust's strategy?	**0.5**	**0.5**	**0.0**	**0.0**	**0.0**
1b. Is the Board sufficiently aware of potential risks to quality?	**0.5**	**0.5**	**0.5**	**0.0**	**0.0**
Capability and Culture					
2a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
2b. Does the Board promote a quality-focused culture throughout the trust?	**0.5**	**0.5**	**0.0**	**0.0**	**0.0**
Processes and Structures					
3a. Are there clear roles and accountabilities in relation to quality governance?	**0.0**	**0.5**	**0.5**	**0.5**	**0.0**
3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
3c. Does the Board actively engage patients, staff and other key stakeholders on quality?	**0.0**	**0.5**	**0.5**	**0.5**	**0.0**
Measurement					
4a. Is appropriate quality information being analysed and challenged?	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
4b. Is the Board assured of the robustness of the quality information?	**1.0**	**0.5**	**0.5**	**0.5**	**0.5**
4c. Is quality information being used effectively?	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
Total	**4**	**4.5**	**3.5**	**3.0**	**2.0**

Oxford University Hospitals NHS Trust

Monitor's Quality Governance Framework Self-Assessment

May 2014 version (v10.6)

Late Draft for submission to trust Board (14/05/2014)

Table of Contents

Overview of Quality Governance Framework Score from July 2012 to the present

	Jul 2012 OUH Self-assessment	Oct 2012 RSM Tenon Score	Dec 2012 OUH Self-assessment	April 2013 OUH Self-assessment	May 2014 OUH Draft Self-assessment (pending Board sign-off)
Strategy					
1a. Does quality drive the trust's strategy?	**0.5**	**0.5**	**0.0**	**0.0**	**0.0**
1b. Is the Board sufficiently aware of potential risks to quality?	**0.5**	**0.5**	**0.5**	**0.0**	**0.0**
Capability and Culture					
2a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
2b. Does the Board promote a quality-focused culture throughout the trust?	**0.5**	**0.5**	**0.0**	**0.0**	**0.0**
Processes and Structures					
3a. Are there clear roles and accountabilities in relation to quality governance?	**0.0**	**0.5**	**0.5**	**0.5**	**0.0**
3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
3c. Does the Board actively engage patients, staff and other key stakeholders on quality?	**0.0**	**0.5**	**0.5**	**0.5**	**0.0**

Measurement					
4a. Is appropriate quality information being analysed and challenged?	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
4b. Is the Board assured of the robustness of the quality information?	**1.0**	**0.5**	**0.5**	**0.5**	**0.5**
4c. Is quality information being used effectively?	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
Total	**4**	**4.5**	**3.5**	**3.0**	**2.0**

This section has been developed to provide contextual background on the Oxford University Hospitals NHS Trust (OUH) to readers of the Monitor Quality Governance Framework self-assessment.

1. Trust Overview

Oxford University Hospitals NHS Trust (OUH) provides a wide range of general and specialist services over four sites: the Churchill Hospital; the John Radcliffe Hospital; the Horton General Hospital in Banbury; and, the Nuffield Orthopaedic Centre. The Nuffield Orthopaedic Centre and the then Oxford Radcliffe Hospitals were integrated to form Oxford University Hospitals NHS Trust in November 2011. This integration coincided with a stronger collaboration with the University of Oxford through a joint working agreement to increase opportunities to translate Oxford-based basic science and healthcare research into new and better NHS treatments.

Since 2010, the Trust's services have been delivered through a clinically-led structure. OUH provides services in more than 100 clinical specialties that were initially grouped into seven clinically-led divisions. These seven Divisions were reduced to five in November 2013 (see figure 1). Services are delivered in a range of locations across Oxfordshire and beyond.

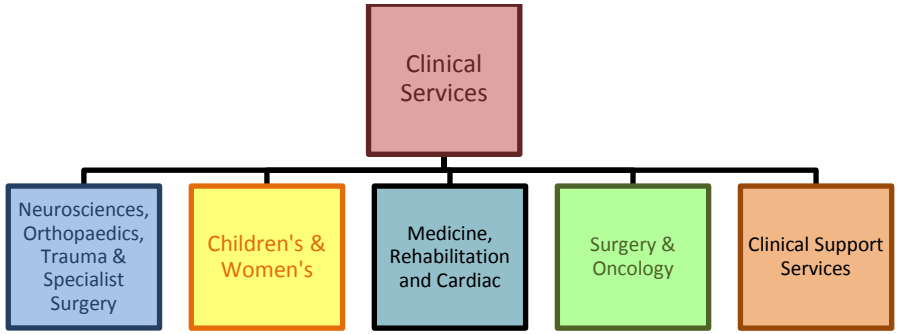


Figure 1 Clinical Services - Divisional Structure

Each Division is led by a Divisional Director, a practising clinician who is supported by a Divisional Nurse (or governance / professions lead) and a General Manager. Divisions are responsible for the day-to-day management, delivery and governance of services within their remit, in line with Trust strategies, policies and procedures. Divisions include two or more Directorates, which are broadly specialty-based and contain a number of clinical service units. The divisional teams include senior staff from Human Resources and Finance (senior business partners) who report to the Divisional Director whilst their professional accountability remains with the relevant executive director. Each Directorate is led by a Clinical Director who is accountable to the Divisional Director, and supported by an Operational Service Manager and one or more Matrons. Clinical divisions are supported by corporate and business support functions, including Finance and Procurement, Planning & Information, Human Resources, Estates & Facilities, the Medical Directorate, the Nursing Directorate and the Assurance Directorate. There are also corporate structures, systems and processes managed and overseen by the Trust's clinical governance and assurance teams to provide internal assurance to the Trust Board, Trust Management Executive and Governance committees.

1.1 Trust Objectives

The Trust has six strategic objectives from which its priority work programmes flow.

- SO1: To be a patient-centred organisation providing high quality and compassionate care whilst promoting a culture of integrity and respect for both patients and staff – "delivering compassionate excellence".
- SO2: To become a well governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – "a well governed and adaptable organisation".

- SO3: To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – "delivering better value healthcare".
- SO4: To provide high quality general acute healthcare services to the population of Oxfordshire including more joined-up care across local health and social care services – "delivering integrated healthcare".
- SO5: To develop extended clinical networks that benefit our partners and the people we serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – "excellent secondary and specialist care through sustainable clinical networks"
- SO6: To lead the development of partnerships with academic , health and social care partners and the life sciences industry to facilitate discovery, implement its benefits – "delivering benefits of research and innovation to patients"

1.2. Quality Strategy

The Quality Strategy for a five year period was approved by the Board in July 2012 and draws on a wide range of work covering patient safety, clinical effectiveness, outcomes and patient experience. The Quality Account for 2013/2014 will be published in June 2014. It reports on the delivery of quality priorities for 2013/2014 and identifies the agreed quality goals for 2014/2015 that are listed below:

- Care 24/7
- Physician input into the care of surgical patients
- Implementation of outcomes of diabetes and pneumonia risk summits
- Timeliness and communication around discharge
- Integrated Psychological Support for Patients with Cancer
- Improvement to the patient experience of outpatients

Quality is the key focus for OUH. Regular reports are brought to the Board, and its Quality sub-Committee, covering all aspects of Quality. In addition, Divisions prepare their own quality reports to review monthly within the division and to present to the Clinical Governance Committee.

1.3. Governance and Reporting Structures

The four Board sub-committees provide assurance to the Trust Board, seeking information from the Trust Management Executive (TME) as required. Each of the four committees with assurance responsibilities report directly to the Board as depicted below in Figure 2.

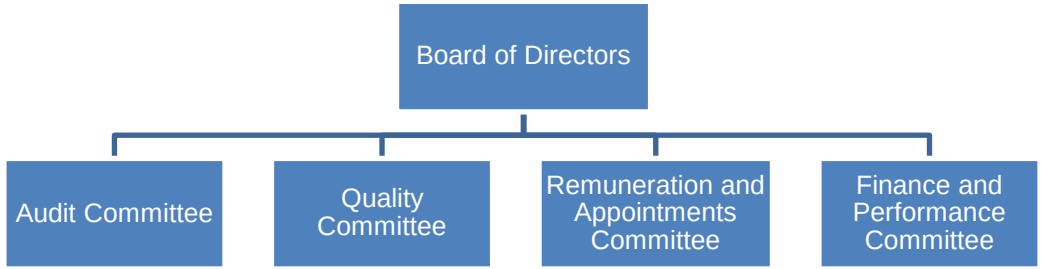


Figure 2: Board Committee and Assurance Structure

The Quality Committee is responsible for providing the Board with assurance on the standards of clinical care, clinical governance and risk management systems, processes and outcomes. The Quality Committee provides assurance to the Audit Committee through review of non-financial risks, specifically in relation to the development and completion of the Annual Governance Statement. It also oversees monitoring of the Trust's compliance with CQC Essential Standards of Quality and Safety. The Quality Committee meets at least six times per year and reports to the Board through the presentation of summaries and minutes.

The Trust Management Executive (TME) is the Executive managerial decision-making body for the Trust. It is chaired by the Chief Executive and consists of the Trust's Executive Directors, the five Divisional Directors and the University of Oxford Medical Sciences Division's Associate Head of Division (Clinical Affairs). It meets once a month and the agenda and minutes of TME are circulated to Board members. The TME has sub-committees which report to it, focusing on specific areas, shown below in Figure 3. Minutes from sub–committee meetings are presented to TME.

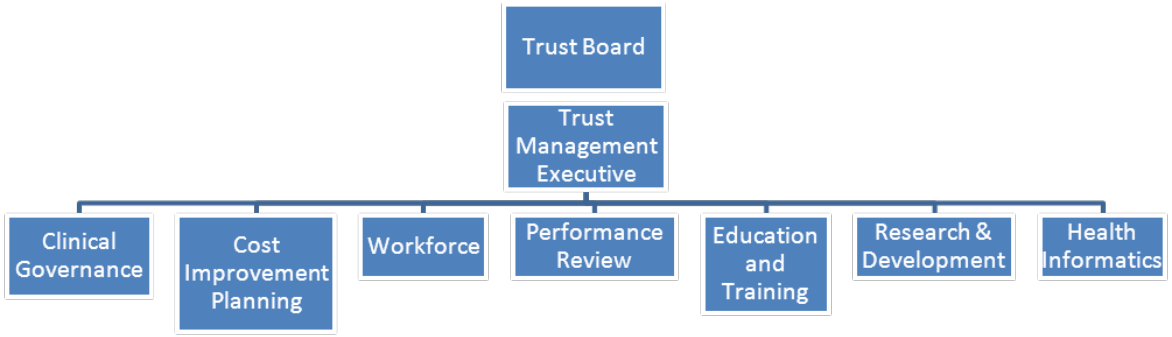


Figure 3 Trust Management Executive - Sub- Committees

These sub-committees support TME to conduct the following functions:

- Monitor the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensure that appropriate actions are taken, as advised by the **Clinical Governance Committee**;
- Oversee the development of the Trust's service strategy by developing proposals for the Trust's strategic direction, as advised by the **Strategic Planning Committee** (SPC), which makes recommendations to TME;
- Monitor the delivery of the Trust's workforce strategy and plans, as advised by the **Workforce Committee;**
- Monitor the delivery of the Trust's service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Trust's objectives or other obligations, as advised by the **Performance Review Committee;**
- Monitor the delivery of the Trust's education & training strategy and plans, as advised by the **Education & Training Committee;**
- Monitor the delivery of the Trust's Research and Development strategy and plans, as advised by the **Research & Development Committee**; and
- Monitor the delivery of the Trust's health information management and technology strategy and plans, as advised by the **Health Informatics Committee**.

1.4. Quality Monitoring and Reporting

The Board reviews monthly performance reports covering finance, performance and quality 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.

An Integrated Performance Report (IPR) was introduced in July 2012. This provides the Trust Board and Divisional Executives with a comprehensive set of performance data covering indicators within the domains of quality, performance, workforce and finance. Some core indicators stem from the NHS Operating Framework, Outcomes Framework and Monitor's Compliance Framework, while others have been identified at an operational level to report on Divisional performance. In addition, a Board Quality report is produced monthly with 54 key quality metrics and exception reporting. This is considered by the Quality Committee in those months when the Trust Board does not meet. .

Monthly Divisional performance meetings take place with each Division led by the Director of Finance and Procurement. These are attended by either the Medical Director, Chief Nurse or a designated representative in order to ensure a focus on quality. These meetings discuss financial and non-financial performance measures, quality, activity and workforce issues. A summary of the quality issues from the performance meetings is forwarded and discussed at the monthly Clinical Governance Committee.

The Clinical Governance Committee monitors the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensures that appropriate actions are taken. It provides a closer scrutiny on these issues than is possible via Divisional performance reviews and, with all Divisions represented, can support consistency of approach across the organisation. Monthly Divisional quality reports are provided to the Clinical Governance Committee and include a standard data set in order to permit internal benchmarking and to promote the use of quality assured data. The Divisional reports also identify trends in complaints and incidents. Lessons from individual incidents are tracked to inform progress along with relevant alerts from Dr Foster and the Central Alerting System (CAS). The Clinical Governance Committee (CGC) reports to the Trust Management Executive on a monthly basis and escalates issues of concern where necessary for information and action.

Governance meetings occur at Divisional level and outcomes are reported via a Divisional quality report to the monthly Clinical Governance Committee. Sub committees of the CGC also provide regular updates. The sub-committees of the CGC include: Patient Safety and Clinical Risk

Committee; Clinical Audit Committee; Clinical Outcomes Review Group; Infection Control Committee; Mortality Review Group; Medications Management and Therapeutic Committee (Figure 4). A number of these sub-committees, namely medicines management, infection control and patient safety and clinical risk have a number of working groups to drive forward areas of work.

Figure 4 Clinical Governance Committee - Main Sub-Committees

Monitor Quality Governance Framework Self-Assessment

Draft - May 2014

Name of leads completing self-assessment:
Mrs Annette Anderson, Head of Clinical Governance
Dr Ian Reckless, Acting Deputy Medical Director

Responsible Director: Dr Tony Berendt, Interim Medical Director

Trust Total Assessment Score = 2.0 (provisional self-assessment)

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	**Evidence**
1a.1. How is Quality embedded in the trust's overall strategy?	The Trust's Integrated Business Plan (IBP) for 2012 / 2017 makes clear that clinical quality is core to all the Trust's activities. This focus upon quality is embedded through the following initiatives and processes. • IBP • Quality Strategy launched in June 2012 and reviewed in September 2013 • Trust's annual Quality Account • Quality is a key focus at regular meetings of the Divisional teams	• IBP • Quality Strategy/ Implementation plan. • Quality Accounts. • Minutes of

	• Quality is discussed and reported at the monthly Clinical Governance Committee. • Quality is discussed and reported at the monthly Divisional Performance Review Committee • Workshops relating to the implementation of the Quality Strategy and other related initiatives • Engagement events in the aftermath of Francis and in the run-up to CQC inspection (February 2014) • Clinical Divisions develop and agree their own quality priorities relevant to their patient groups. These are displayed in relevant clinical / service areas and are measured and reported regularly (progress reported to CGC in February / March 2014) • Publication of Quality Matters newsletter that includes relevant articles and initiatives relating to quality and safety of patient care and is disseminated to staff. • Revised 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 • Bi-monthly 'all staff' and Senior Team briefs conducted by the Chief Executive (or Executive Colleagues) • All Divisional annual business plans reference their quality priorities for forthcoming year • A Quality Impact Assessment is embedded into the process for establishing Cost Improvement Programmes (CIP) • Listening in Action (LIA) quality awards • Definition and circulation of required standards for local clinical governance mechanisms • Implementation of a Peer Review Program (2013/14) • Implementation of a programme of risk summits (2013/14)	Divisional meetings. • Minutes of Performance and Clinical Governance Committees • Integrated Performance report • Quality workshop agenda, slides and attendance. • CEO and Team briefs. • Template for Trust business cases • Division business plans for 2014 /2015. • QIA for CIPS. • Quality reports • LIA quality awards • Expectation of Divisions for clinical governance • Divisional quality posters

		• Francis Report briefings • Divisional Peer review reports • TME Papers updating progress with regard to peer review and risk summits
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 outcomes and patient experience were captured in the Trust quality strategy utilising information relevant to our patients including: • Local Quality Priorities • National Quality Priorities • CQUIN contracts • Divisional quality priorities • Dr Foster reports and alerts • National and local patient experience surveys & stakeholder events The strategy promotes improvement year on year, driven by / monitored through: • Annual Quality Accounts • Divisional quality reports • Monthly Quality reports to Trust Board • Quality priorities/ metrics and trend analysis reported in Integrated Performance report (IPR) • Discussion and reporting of quality through the Trust and Divisional Performance and the Clinical Governance Committees structure • Development of quality priorities and metrics at divisional level,	• Quality Strategy and implementation plan. • Quality Account • Monthly quality reports to Board • Integrated Performance report • Divisional Quality reports • Divisional quality Priorities • Minutes of Performance and Clinical Governance Committees • National and local patient experience

	set against the 3 Darzi domains • Implementation of electronic incident reporting system (Datix) has improved the reporting, collation and analysis of information related to incidents and associated risks for clinical service units, Divisional teams and corporate services • Annual review and evaluation of Organisational Quality Priorities	surveys & stakeholder events • Annual Business plans including Quality Priorities. • Formal reporting of achievements against Quality Priorities at all levels of the organisation to the Clinical Governance Committee
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?	Quality goals are identified with reference to: • National priorities set out in the NHS Operating Framework • Mandated and locally negotiated CQUIN projects • Complaints • Patient involvement groups • Dr Foster reports and alerts • Information from incident trends on Datix • Clinical Governance Committee planning & review workshops (February 2012, February 2013) • Patient engagement events attended by Board members • Patient and staff feedback • CQUIN contract • Dr Foster reports and alerts • Risks identified on risk registers (corporate, divisional, directorate) • Data relating to reported incidents	• Quality Accounts • Divisional quality reports. • Integrated Performance report. • Divisional Business Planning. • Minutes of CGC away day and planning and review workshop • Patient

	• Commissioner feedback • Internal and external stakeholder events conducted by Board • Executive Quality walk rounds • Peer review Program • National Clinical Audit Reports • Risk summit programme In relation to impact, local quality priorities are developed at service level to support the overall Quality Strategy based on local intelligence relating to safety, patient experience, outcomes and effectiveness. These quality priorities are displayed in each service area to increase the local profile and buy-in. Divisional priorities form part of the Divisional business plans. The profile and monitoring of progress of quality goals is maintained through the Divisional and Directorate structures. Divisions are required to report progress against local Quality Priorities in their monthly quality reports which are tabled at the Clinical Governance Committee. These reports are merged to create a Quality report that is submitted to the Quality Committee and then to the Board. • Quality measures in the Oxfordshire CCG contract are monitored through monthly joint contract meetings. Issues relating to service performance are raised with the respective service and progress monitored through the performance review meetings. • Development of Quality priorities and metrics at Divisional level. These are set against the 3 Darzi domains and are relevant to their own clinical practice. They are presented and discussed at monthly Divisional meetings During 2013/14, a programme of Divisional Peer Review was undertaken. Actions identified from each peer review are monitored both at Divisional level and through reports to TME. In addition, a programme of Risk Summits has been arranged. The risks identified	engagement events • CQUIN targets • Minutes of joint contract meetings • Minutes of CQUIN meetings • Example of quality improvement initiatives • Action Plans after Executive walk rounds • Risk summit materials and work plans. • Reports from peer review and action plans • Contract Review Meeting Agenda and minutes.

	tend to relate to pan-Trust issues relating to clinical care and/or clinical process. The topics are identified on the Trust risk register. Examples include inpatient diabetes, community acquired pneumonia and out of hours care. These mechanisms ensure that priorities are identified in a robust fashion and that profile and impact is maintained.	
1a.4. How do quality goals reflect what is relevant to patients and staff?	Quality goals reflect what is relevant to patients and staff through consideration and analysis of feedback from the following initiatives and processes: • Stakeholder events • Analysis of incidents • CQUIN development, milestones and evaluation with commissioners • Patient and staff national survey results • Internal patient and staff feedback surveys • Executive Quality walk rounds • Complaints • The NHS Operating Framework/ Outcomes Framework. • Staff suggestion scheme • LIA programme • Raising concerns • PALS feedback • Patient involvement groups • Effective staff and patient input was achieved through the peer review process • Patients participating in peer review program • Patients and staff participate in the risk summits	• Stakeholder events • Patient engagement events • Data from Datix • Patient and staff surveys • Quality walk rounds • Staff suggestion scheme • PALS • Patient involvement groups • Reports from peer review
1a.5. Demonstrate that quality goals wherever possible are specific, measurable	The Trust and Divisional quality priorities are linked directly to the Trust quality goals. Quality priorities are set by each Division /	• Division quality priorities and

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.	directorate and service area at the beginning of each financial year according to their CSU clinical speciality. These are measured and discussed monthly through the performance and governance committee structure at Divisional level. A cohort of high level metrics for the Trust quality priorities are measured, reported and trended monthly though an integrated performance report at divisional and Trust level. Division Quality reports contain clearly defined measures of quality that are regularly reported on as well as bespoke measures that relate to particular service areas. Since April 2013, there has been an emphasis on holding quality data centrally in a data warehouse and ensuring quality assurance of the data streams. The data are reported from the warehouse for various purposes. A series of dashboards are used along with line graphs for exception reporting where the principles of statistical process control (SPC) are used in order to promote proportionate and insightful interpretation of figures.	business plans • Quality Posters • Quality Account • Divisional quality reports • Board Quality Report
1a.6. Are there clear action plans for achieving the quality goals with designated leads and timeframes?	Specific action plans for local quality goals for the forthcoming year are in place. Trust quality goals are monitored through monthly contract meetings with commissioners and internally through: the Divisional Performance meetings; Clinical Governance Committee; Infection Control Committee; Patient Safety and Clinical Risk Committee; Trust Management Executive and the Trust Board. All five Divisions have an internal governance structure to identify, monitor and resolve key issues related to patient safety, experience and effectiveness.	• Minutes of relevant meetings • Divisional business plans • Trust business plan • Action plans • Minutes of divisional Performance meetings
1a.7. Demonstrate how quality goals are effectively communicated and well-	Quality goals are communicated across the Trust using a number of methods:	• Patient and staff involvement

understood across the Trust and the community.	• A Patient Engagement event in April 2014 reviewed progress against last year's goals and tested the proposed priorities for the year ahead • The Quality Account and Quality Account 'At a Glance' summary document is published on: Trust's intranet; internet site and through NHS Choices • The OUH website provides information and updates to patients, the public, staff and the wider community on all aspects of the Trust's activities • Trust-wide 'global' email • Chief Executive Briefings • Quality workshops • Implementation of Quality strategy • Quality posters being produced for each service area • Quality Matters newsletter • Staff induction / appraisal programme • LIA programme • Staff and patient engagement events • Patient involvement groups • Executive walk rounds • Clinical Divisions develop and agree own clinical outcomes and priorities relevant to their patient groups. These are displayed in relevant clinical / service areas and are measured and reported monthly through Divisional Clinical Governance Committees • Development of quality messaging on screensavers and wallpaper on Trust IT systems • The Trust's ORBIT data warehouse system has been developed to permit relatively open access for staff to data relating to activity, performance and quality. ORBIT produces a wide variety of reports including at Consultant level for performance management (e.g. VTE risk assessment), Consultant level for appraisal, and at various other levels (Trust, service, directorate,	groups • OUH news • Staff briefings • Intranet / Internet • Quality Account and summary • Quality Strategy • Quality Posters • Quality Matters newsletter • Staff induction and appraisal programme • LIA programme • Executive walk rounds • Outputs of ORBIT data warehouse

	Division)	
1a.8 How does the Board regularly track performance relative to quality goals?	The Board tracks performance relative to quality goals by; • Monthly report from CGC is submitted to Trust Board and Quality Committee (minutes with brief explanatory narrative) • A monthly Board Quality Report is submitted to Trust Board and Quality Committee providing an update against a variety of quality related issues and programmes of work, including a standardised dashboard with 54 metrics (with SPC charts for exception reporting where appropriate) • Monthly Divisional performance meetings are attended by a representative of the Medical Directorate who has a specific remit for quality governance. Actions relate to a range of issues including: quality; finance; operational performance and CIPs • The Board Integrated Performance Report (IPR) measures performance compared to national targets and comparable hospital clusters • Patient stories and service presentations to the Board • The outcomes from Executive walk rounds form part of the Divisional quality reports • Outputs of Risk Summits and Peer Review are fed back to the Board • The Quality Committee receives updates on specific topics either in accordance with the annual business plan and / or on an ad hoc (requested) basis	• Divisional quality reports • Board Quality Report • IPR • ToR of committees • Executive walk rounds • CGC minutes to Quality Committee • QC papers • Peer Review • Risk Summits
1B. Is the Board sufficiently aware of potential risks to quality?	**Trust assessment (score): *GREEN / Score 0.0***	
	Response	**Evidence**
1b.1. How does the board regularly assess and understand current and future risks to	• The Trust's risk management strategy outlines how risks are escalated upwards through the divisions and to Trust Board where required.	• Executive walk rounds • BGAF and CRR

quality? What steps does the board take to address current and future risks?	• The Audit, Finance and the Quality Committees review the registers as part of their assurance functions. • Risks in relation to specific areas of performance, finance, and workforce are included within relevant Board reports. • The Board Governance and Assurance Framework and Corporate Risk Register are updated quarterly and presented at least every 6 months to the Board. • Reports on complaints and patient experience information are provided to the Board with information on key areas of concern to patients and their families. • Executive and Non-Executive Directors take part in Executive Quality walk rounds and outcomes are reported through Divisional Quality reports, and separately to the Quality Committee. • 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. • CIP templates include risk of delivery and are signed off by: Clinical Lead; Divisional Director; Chief Nurse; Medical Director and Director of Clinical Services. • All CIPs have an initial Quality Impact Assessment which is updated using a series of quality metrics and reported at monthly Divisional performance meetings. Progress against CIPs is provided quarterly to the quality committee. • The Board receives regular reports on financial performance which include progress on the savings programme. A review including the risk of non-achievement is carried out on a weekly basis for the Director of Finance and Director of Clinical Services. • Board members participate in the Peer Review Programme	• Relevant Board reports • Patient story programme for Board • Progress against CIP programme

	• Board members participate in the Risk Summit Programme	
1b.2. Does the board regularly review quality risks in an up-to-date risk register?	Yes. The Corporate Risk Register (CRR) is reviewed by the Board on a regular basis. The template through which the Quality Committee reports to the Board incorporates a risk section.	• CRR • Minutes of Board meetings • Quality Committee report
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 relating to quality, 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').	• Escalation process for corporate risk register • Risk management toolkit • Risk Tool Kit
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 is included in the executive summary of the Board Assurance Framework (BAF) and the CRR document. They are reviewed and updated in line with the quarterly review process but have also been added to following discussions on emerging issues noted through other committees. For example, a recent version included a note about the change in commissioning arrangements highlighted by the Finance & Performance Committee. A good example of this would be the inclusion of out of hours care on the risk register and the development of a risk summit programme on the same (OOH care was identified as an issue through the Peer Review and also through the external environment – RCP Future Hospitals Commission). The Technologies Appraisal Group (TAG) has responsibility for assessing the risk of new technologies prior to being used in the clinical environment.	• BAF • CRR document • Risk register • Minutes of TAG • Risk summits

1b.5. Is there clear evidence of action to mitigate risks to quality?	Yes. • All risks on the corporate risk register are categorised and assigned to an executive lead • The Board reviews the Risk Register to monitor existing and potential new risks • Risks are monitored and managed through the committee structure. • The BAF and risk register are reviewed by the Board, with a more detailed review undertaken by the responsible subcommittee. However if there are any major issues these are escalated to the board when required, for example; Accident and Emergency at the Horton • Risk summit process and outcomes in relation to diabetes, pneumonia and out of hours care • Action plans following on from Executive Walk Rounds and Peer Review	• QIA for CIPS • Minutes of monthly performance meetings • Trust Board papers
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. • All CIPs have a Quality Impact Assessment (QIA) conducted, which provides a structured approach to assessing the potential positive or negative impact on the delivery of services and the quality of care. The impact is monitored by review of the KPIs that correlate to the respective quality indicator. If the potential impact is negative, actions to mitigate the impact and risk must be stated. • CIPs are assessed at performance review meetings to provide assurance that the risks and impact are being appropriately managed. • The Quality Committee oversees the CIP process. • This complements the business planning / business case process which also takes quality into account.	• QIA • CIP reports to QC • CIP evaluation through quarterly Performance Meetings.
1b.7 Are initiatives with significant potential to impact quality supported by a	• All business cases, CIP programmes and improvements projects follow a standardised process and undergo an assessment for	• Template for business cases

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)**	quality, informed by the LEAN methodology and internal and external benchmarking where appropriate. • The assessment for quality and risk compares indicators such as number of complaints and mortality. Indicators are monitored and reviewed quarterly as part of regular performance meeting. • External benchmarking occurs via: the Shelford benchmarking group; Dr Foster; NPSA six monthly Organisational incident analysis report comparing 30 teaching organisations and the Insight Analytics Acute Trust Quality Dashboard (ATQD) • An example of an initiative is the Endoscopy efficiency project, which improved throughput without impacting on quality	• Example of business cases • Evidence of Shelford benchmarking group • Insight Analytics (previously EMHO) ATQD • NPSA six monthly Organisational incident • Endoscopy efficiency project
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?	• Each initiative has a set of mandatory key quality measures and early warning signs identified by the proposer of the initiative at clinical service level • Quality is measured before and after implementation and monitored at performance meetings and a quarterly update is provided to the QC. • If specific quality indicators such as complaints or incidents identify a problem with a CIP a root cause analysis is undertaken. • Where possible, candidate indicators for the monitoring of CIP are drawn from existing quality assured metrics rather than developed specifically in relation to the CIP.	• Example of CIP template • QIA • CIP quarterly report for QC
1b.9 How is the board assured that initiatives have been assessed for quality?	The Board is assured that all initiatives have been assessed for quality as they all follow a standardised format. • Each CIP has a quality impact assessment which is monitored	• Business case template

	and reported on against quality metrics determined at the time of commencement. These metrics are discussed at the monthly divisional performance review meetings. • All business plans follow a standardised format including undertaking a review on the impact of quality. • All service improvement projects measure the impact against the three quality domains: patient safety; patient experience and outcomes and effectiveness.	• QIA • Example of SI project
1b.10.How are clinicians involved in the development of CIPs and other initiatives and are they accepted, understood and owned by relevant clinicians and clinical directors?	• CIPs are developed in advance with the involvement of Divisional Directors, Divisional managers and lead clinicians. These individuals specifically sign off each CIP. • Clinicians are directly involved in the delivery of CIPs, each CIP is signed off by the clinical lead for the specific CIP, together with the respective Divisional Director • A detailed CIP development template is used throughout the organisation that requires clinical and non-clinical managers to specifically consider a number of quality domains. • These templates 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 monitor the delivery of financial and other performance targets whilst maintaining a focus on clinical quality.	• CIP process document • CIP information on Intranet • CIP summary sheet • QIA • Minutes of relevant 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 Trust has a 'Raising concerns (whistle blowing) Policy' which is communicated to staff through the; • Staff induction programme • LIA programme launched in 2012 • Trust Intranet • Annual staff survey results showed staff are prepared to raise concerns • There is evidence that staff use the policy through emails, phone calls and letters, and this policy was further highlighted at the Francis briefing sessions, attended by > 750 staff in February / March 2013. • Updates on staff raising concerns are outlined at the Workforce Committee • Updates on staff raising concerns relating to quality are outlined at the Clinical Governance Committee as a standing item (and reported on to TME and Quality Committee / Board).	• Raising concern (whistle blowing) policy • Staff induction programme • Data from raising concern feedback • Action taken from feedback • Francis report presentation • Workforce committee minutes • CGC agenda and minutes • Board papers
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	**Evidence**
2a.1. Is quality performance subject to rigorous board challenge, including full NED engagement and review? (either through participation in Audit Committee	Yes. The Board reviews quality performance each month in several ways including: • Quality reports to each Board meeting cover all aspects of quality, including quality indicators. Reports on day-by-day	• Quality reports • NED and Executive involvement of

or relevant quality focused committees and sub-committees)	nurse staffing levels on each ward are in development. • Board minutes show a track record of non-executive questioning to clarify and provide further information around many issues, including those relating to quality of patient care • There is input and challenge from NEDs in relation to issues of quality including patient experience, the delivery of actions arising from the safety walk round programme, same sex accommodation and the identification of accountability • 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 • The Quality Committee receives a detailed patient story at each meeting and monitors the completion of actions arising from the experiences described • NEDs are part of the Executive walk around programme that scrutinises quality of care at ward and department level. This gives them insight into how wards are managed and any concerns around quality that are raised by staff, patients and relatives • Annual reports are presented on: clinical and non-clinical risk; Operational performance; complaints and infection control in addition to other monthly reports • 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 • 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	Executive walk rounds • Outcomes from walk rounds in quality reports • CGC action plans • Board minutes • Outputs of risk summits • Outputs of peer review

	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 • Minutes of the CGC meetings are routinely presented to the Quality Committee and key issues arising from the CGC meetings are subject to further analysis at the Quality Committee • Board members attended Trust's Francis briefing sessions in March 2013, enabling them to get a feel for staff views around quality • Active participation of Board members (ED and NED) in Risk Summits • Active participation of Board members (ED and NED) in Peer Review	
2a.2. Are the capabilities required in relation to delivering good quality governance reflected in the make-up of the board?	Yes. • There has been consideration 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 appropriate balance between Board members who are new to the Board and those who have served on the Board for longer • The Board members have experience at board level in the NHS and/or in the private sector • The Chairman of the Board has demonstrable and recent track record of successfully leading a large and complex organisation • Board members have taken a keen interest in Human Factors	• Board and sub-committee reports on effectiveness • Notes of Board feedback, Board membership breakdown and biographies

	and similar issues	
2a.3. Are the Board members able to: **1. Describe the trust's top three quality-related priorities.** **2. Identify well- and poor-performing services in relation to quality and actions the trust is taking to address them.** **3. 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.** **4. Be clear about when it is necessary to seek external assurances on quality e.g. how and when it will access independent advice on clinical matters**.	1. The Trust describes six quality priorities for 2014/15. These are • Care 24/7 • Physician input into the care of surgical patients • Implementation of outcomes of diabetes and pneumonia risk summits • Timeliness and communication around discharge • Integrated Psychological Support for Patients with Cancer • Improvement to the patient experience of outpatients 2. Members of the Board have a clear view of those services in the Trust that provide outstanding care and are aware of those services where further development is necessary. Action is taken where necessary to address any concerns. 3. A range of external metrics to monitor performance are used and are included in performance and quality reports including the Integrated Performance Report and Commissioner's contract schedule 3, part 4. These originate from the NHS Operating Framework, ATQD and Dr Foster, Shelford Group and national audits. NICE Recommendations are managed through a central register and lead clinicians assess the implications and action required. 4. Yes, the Board initiates external and independent reviews where assurance is required to advise on further developments	• Min requirements Document • Quality Strategy • Trust Quality priorities for 2013/14 and 2014/15 • CQUIN • CQC views on DANI in Medicine • Fractured NOF performance • Clinical audit report • Minimum requirements of clinical governance • Report into Laparoscopic cholecystectomy at the Horton
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	Yes , examples of where board has made an impact on improving quality include: • Medical Director leading on Quality Strategy and the development of quality workshop quality priorities and	• Patient stories at Board level • Programme for patient stories

role in leading on quality)	outcomes. • Increased investment in the number of obstetric and Emergency department consultants • Improving compliance with the WHO checklist • Reducing the incidence of MRSA and *C Difficile*, hospital acquired pressure ulcers and falls, by raising the profile of all aspects of infection control via the Board. • LIA programme led by Chief Executive • Patient experience lead by Chief Nurse • 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. • Leadership of Risk Summit Programme (and in particular Quality Committee and diabetes) • Participation in feedback session relating to Peer Review	• Quality priorities for 2013 -2014, & 2014/15 • Slides from summary of Francis report • Quality on the Intranet • Peer Review work plans • Risk Summits action plans • Exec Walk Round action plans
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?	Yes. Formal evaluations of the Board have been undertaken 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 2014, the trust Development Authority observed a meeting of the Quality Committee • From January 2013, the Board and its sub-committees have been engaged in an effectiveness programme involving the completion of self-assessment questionnaires, semi-structured interviews and a desktop review. The outcome of this work was presented to the Board at its meeting in May 2013 • At the end of each Board meeting, feedback on various aspects of the conduct of the meeting is provided by a pre-selected member of the Board. Issues considered include how well the	• Board and sub-committee reports on effectiveness • Notes of Board feedback • Cycle of business • Feedback following SHA and TDA observation

	Chairman ran the meeting, the balance of time spent on performance, quality and strategy issues, the quality of the papers and the quality of debate. A note of this feedback is taken and is incorporated into the Board Development Plan 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 a 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 • Progress against the Board Development Plan which included an action plan, based in part on these evaluations, was presented to the Trust Board in June 2012 • Board Development Plan included in cycle of business Trust Board The formal evaluations conducted have included a range of evaluation methods. However, the Board is mindful that in this process it is yet to include the views of other stakeholders such as staff and commissioners. Formal evaluations of the Board have included all dimensions of	

	effectiveness. The external evaluations considered the content of Board and Committee meetings. 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 functions.	
2a.6. Do board members attend training sessions covering the core elements of quality governance and continuous improvement?	Yes. • All Executives have a personal development plan as part of the appraisal process • Processes are in place to ensure development of the corporate role of Executive Directors as part of their personal development plans and Board development programme. • Board members can evidence improvements that they have made in the quality of their contributions at Board level • The Board receives a range of training and attend development sessions and seminars including quality workshops, risk management training and Human Factors training. • Non-executive directors have received specific briefings including on financial matters and CQC risk assessment methodology • Non-executive directors have attended external briefings by the FTN on quality governance	• Evidence from BGAF • Board Seminars • Annual Appraisal of Board members • Personal development plans. • Board development programme.
2b. Does the Board promote a quality-focused culture throughout the trust?	**Trust assessment (score): *GREEN / Score 0.0***	
	Response	**Evidence**
2b.1. Does the board take 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	Yes. • The Board has debated and agreed a set of quality and financial metrics outside the national and regionally agreed metrics • All CIPS have completed QIA and are signed off by the Medical Director, Chief Nurse and Director of Clinical Services	• Executive walk rounds • QIA / CIP programme • Metrics agreed

organisations)	• An integrated peer review process has been undertaken, with extensive Board level involvement and sponsorship. • Board members (Non-executive and Executive) take part in a full and regular programme of quality walk-rounds across all areas of the Trust. Updates on issues identified and actions taken are included within the Quality Reports to the Quality Committee, and in 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. • A Non-Executive member of the board chairs the QC and he has championed a number of focussed quality initiatives, including helping to bring about improvements in the administration of Outpatient services • Non – Executive and Executive members of the board attended the quality workshops and participated in both the risk summits and the peer review programme. • The board reviews key national reports into service failures and/or service reviews to highlight organisational learning for OUH. This includes lessons learnt from e.g. the Francis Report, Healthcare for All, Ombudsman summary reports. • OUH is a member of the Shelford Group of teaching hospitals and thereby has access to benchmarking data covering a number of key indicators	by board • Minutes of board meetings re discussion of major reports • Healthcare for All • Ombudsman (PHSO) summary reports • Trust responses to Francis report • Quality Committee minutes
2b.2. Does the board regularly commit resources, time and money to the delivering of quality initiatives?	Yes. • A range of business cases are submitted to the Trust Board for support and approval • Board seminars include discussion of issues relating to risk	• Board minutes for 2012 – 2013 with business cases

	management and quality Examples of investment include • Additional investment in consultant staff in obstetrics, the emergency department and acute general medicine to improve patient experience, safety and outcomes • Supported Hospital Discharge Service implemented in 2012 aimed at getting patients home when they are medically fit, thereby bridging the gap between being discharged from hospital and awaiting community service support • The new build of the Neonatal Intensive Care Unit at the John Radcliffe Hospital • Additional recurrent investment to support the management of inpatients with diabetes	• SHDS • Obstetric investment • Diabetes service review business case
2b.3. Does the board actively engage in the delivery of quality improvement initiatives and are some initiatives led personally by board members?	Yes. • The Chief Executive leads the LIA programme. • Chief Nurse leads on delivery of 'Compassionate Excellence' • The Medical Director leads on the Quality Strategy • Director of Clinical Services is actively engaged in the Supported Hospital Discharge Service in collaboration medical clinicians and is the lead director for delivering the CQUIN quality improvements. • The Director of Assurance ensures that the Trust maintains a critical and analytical approach in determining gaps in Assurance and areas that require further improvement. • Medical Director leads the risk summits • Medical Director and Director of Assurance jointly lead the peer review programme	• LIA programme • Compassionate Excellence • SHDS • 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	Yes. • Quality strategy developed in 2012 and its profile was raised through a quality workshop in October 2012 • Quality forms part of all agendas at Divisional and service level.	• Quality strategy workshop • Divisional quality priorities

the quality strategy is and can they define the trust quality priorities for the forthcoming year?	• Directorates, Divisions and Service areas have set their own quality priorities and outcomes for 2013 – 2014 specific to their patient needs and are linked to trust quality goals. • Quality Priority posters are displayed publicly in service areas. • Listening in action programme is linked to the Quality Strategy. • Trust induction programme includes elements on risk management, trust values and quality. • Mandatory and statutory training programme results for 2012 – 2013 showed an increase in the number of staff completing mandatory training. • The Medical Director has encouraged any member of clinical staff to raise any quality based concerns that they might have, and these are reported to the Board via the Quality Report, along with details of actions taken to address them • Risk summits are intentionally open and inclusive (with the care 24/7 summit being a particular example).	• Results of statutory mandatory training • Care 24/7 risk summit attendance and communications • Inpatient diabetes risk summit attendance and communications • Pneumonia risk summit attendance and communications • Peer review Participation records
2b.5. Do staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment)	Yes. • Staff members appear to feel comfortable reporting harm and errors. This has been supported by the introduction of the Electronic reporting system 'Datix' as system is more accessible, efficient and the number of reported incidents within the Trust has increased. • Staff survey results (Feb 2013) showed more staff feel comfortable reporting harm and errors than in previous surveys. • The Listening into Action (LIA) programme sessions allowed staff opportunity to openly discuss issues and concerns. • Clinical staff have started to raise concerns directly to senior staff	• Staff survey results • Data from Datix • LIA programme feedback information

	and these have been picked up through the Quality Report • Approximately 1000 staff attended sessions in the aftermath of the Francis report and demonstrated a willingness to identify and talk about 'difficult or challenging' issues.	
2b.6. Are staff entrusted with delivering the quality improvement initiatives they have identified and are they held to account for delivery?	Yes. • Divisions set their own quality priorities and monitor them though the Directorate and Divisional structure. • Quality improvement initiatives are either developed through the divisions or by the corporate service improvement team. These initiatives are communicated and presented through the divisional and corporate structure through clinical governance committee meetings. • Business cases are presented and monitored through the TME. • Action plans are developed and many are monitored through relevant committees, including Clinical Governance Committee	• Annual plan of work from service improvement • Examples of service improvement projects at Divisional level • SHDS project • Examples of business cases • Minutes for TME
2b.7. How are the quality vision and quality goals communicated across the organisation e.g. internal communications, monthly newsletter, intranet, notice boards, and regular feature articles on quality.	The Quality vision and goals are communicated through; • Stakeholder events • Intranet / Internet • Quality banners • Divisional Quality priority posters • LIA programme • OUH news • Quality workshops • Staff briefings • Team briefs • Staff appraisal • Staff induction programme • Quality Matters newsletter • Quality Account (and easy access version)	• Slides from public engagement events • Quality posters and banners • LIA programme and results • OUH news • Quality workshop outcome • Staff and team briefings • Staff induction and appraisal programmes

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	**Evidence**
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 accountability and responsibility for delivering quality is outlined below. Further information regarding the Trust's organisational and reporting structure can be found in the Trust overview at the beginning of this document. • 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 integrated performance report provides the Board and Divisions with a comprehensive set of performance data covering indicators within the domains of quality, performance, activity, workforce and finance. • Monthly performance meetings with each Division address: financial and non-financial performance measures; quality; activity and workforce. Challenges and performance are discussed in detail by the Executive team and actions are agreed	• Divisional quality reports • Minutes from CGC meetings • Quality reports to the Board and Quality Committee • IPR • Trust board minutes • Minutes of performance meetings

	to mitigate emerging risks and to manage performance. • The Quality Committee is responsible for providing the board with assurance of standards of quality and safety and report to the Trust Board. • The Clinical Governance Committee's supporting committee structure covers: all aspects of clinical governance; patient safety; infection control; clinical audit; clinical risk management and health & safety. • The Divisional Directors are accountable for the delivery of all aspects of performance and quality and this is discharged through the clinical services, clinical directors and their teams. • Divisional nurses and matrons have a specific role in the delivery of the quality agenda, and are accountable to the clinical directors. • Quality-related issues are discussed and acted upon at Divisional meetings. Each Directorate is accountable for governance through its Clinical Director with the Divisional Director being accountable to the Director of Clinical Services. Each division provides a monthly quality report to the CGC. Local staffing solutions and structures vary according to the nature of clinical services and the scope of quality improvement and governance work.	
3a.2. Does each board member understand their ultimately accountable for quality?	Yes. • Board members understand their accountability for quality and each year 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 • Review of BAF and supporting processes support understanding in relation to quality governance and assurance	• Quality Accounts • Minutes and agenda of board away days • Board Seminars • Induction programme • QC minutes

	• The Board has paid specific attention to reports from the 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 • Executive and non-executive members of the board attended the Quality workshop in 2012 and were involved in the development of the LIA programme • The Trust is compliant with the recommendations outlined in the document 'Healthcare for all' as reported to the Quality Committee in April 2013	
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, as described above, quality is a standing item on the main board agendas and is integrated in major discussions as evidenced through the Integrated Board report, monthly quality report, business cases, patient stories and CIP programme.	• Board agenda and minutes • Quality reports • Business cases • Evidence of patient stories
3a.4. Is quality performance discussed in more detail each month by a quality focused board sub-committee with a stable and regular attending membership?	Yes. The Quality Committee is a sub-Committee of the Trust Board and discusses quality performance in depth at least 6 times per year and has a regular membership including 4 Non-Executive Directors (including the Chair of the Trust), the Chief Executive, the Medical Director, the Chief Nurse, Director of Assurance, Director of Workforce and Director of Clinical Services. The Clinical Governance Committee a sub-committee of the Trust Management Executive (TME) meets monthly to review quality performance of each division and pan-Trust. It has a regular membership including the Medical Director, the Chief Nurse and Head	• Minutes of quality committee • Quality report • Minutes of Clinical Governance Committee

	of Clinical Governance. A quality report is produced each month and submitted to either the Quality Committee or the Trust Board (according to the meeting schedule).	
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	**Evidence**
3b.1. How are quality performance issues escalated to the board and is the process clear and well documented?	• Escalation is through the Trust's Divisional and Committee structure through a combination of: routine papers; discussion and review of risk registers. • In addition, other less formal mechanisms (quality walk rounds) provide Board members with alternative insights and an opportunity to cross check information presented in formal reports. Summary reports on actions taken are included in Quality Committee reports • Quality reports feature on each Board agenda and in addition, the Quality Committee receives detailed reports on a number of specific aspects of quality. • 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. • There are clear mechanisms in relation to: the route via which CGC escalates to TME +/- Quality Committee (minutes have cover sheets with key issues for information or escalation) and the route via which Divisional and Corporate risks are escalated	• Board Quality reports • IPR • Quality walk rounds • HSMR/SHMI reports • Infection control reports • Pressure ulcer reports • Risk Management Strategy • Minutes of CGC for TME / QC • Risk registers

	to the trust Risk Register.	
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 local managers and/or the Risk Management Team. For more serious incidents, categorisation is discussed with the Medical Director 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 via STEIS • 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 NHS England • Issues relating to bed capacity and breaches in A&E are escalated through the Director of Clinical Services and appropriate Divisional managers • Quality issues are raised and escalated through the CGC and QC where appropriate • The monthly quality report provides information relating to concerns raised by staff • A degree of detail in relation to SIRIs is provided – The Board Quality Report includes the number and headline topic of each newly declared SIRI. Every other month, Quality Committee receives a synopsis of those SIRIs that have been recommended to the CCG for closure	• Risk toolkit • Complaints policy • Incident reporting policy • Quality Committee routine SIRI paper
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**	Yes. 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, Patient Safety and Clinical Risk Committee and, when required, the	• Action plans from SIRIs • Complaint action plans • Legal action plans

followed up at subsequent board meetings?	Trust Management Executive and the Trust Board.	• CGC minutes • Patient Safety and Clinical Risk Committee minutes • Paediatric Cardiac action plan
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 other quality-focused meetings. A wide range of the key performance indicators are related to patient safety, access to diagnosis and treatment, national targets as part of the schedule 3 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. Quality performance issues are also highlighted through team briefings sessions and Divisional meetings. There is also extensive Divisional representation at CGC and Performance Meetings. Changes have occurred in 2014 in order to introduce SIRI closure meetings (as opposed to using a more formal Committee meeting for this purpose). The goal is for investigators, the department involved and corporate experts to review an investigation report, ensure that it is adequate and met ToR, provide challenge and actively consider how transferable learning might be and the appropriate communication steps. The Risk Summit process has provided an important vehicle over 2013/14 to drive concerted action in response to quality performance issues. Diabetes, pneumonia and Care 24/7 risk summits would each provide a good example of pan-trust work following on from	• Performance meeting records • Team briefings • Contract meeting minutes • Risk Summits • Peer Reviews

	identification of a perceived / potential quality performance issue.	
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?	• Divisional representatives contribute to the Trust's Clinical Audit Committee which 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) • 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 commissioned KPMG to review the clinical audit process – which offered significant assurance - and recommendations from the report have been implemented. • Annual clinical audit report provided to QC providing: assurance that evidence based medicine is being provided; identification of gaps between practice and standards; presence of appropriate action plans to close gaps and the closure of those gaps. • Annual clinical audit report provided to AC updating progress against agreed annual audit plan and compliance with own policies.	• Clinical audit policy and process • Clinical audit reports to CGC • KPMG report • KPMG action plan • Annual Clinical audit reports to QC and CA committees
3b.6. Is there a continuous rolling programme of audits that measures and improves quality? Are action plans	• There is an annual Clinical Audit Programme, approved and monitored by the Clinical Audit Committee (CAC), the priorities for which are set out in the Clinical Audit Procedure. The	• Clinical audit strategy • Annual audit

completed from audit and are re-audits undertaken to assess improvement?	Clinical Audit Programme includes Trust involvement in; rolling National Clinical Audits, Audits determined by our main commissioners and local divisional audits related to local risk and quality priorities informed by the risk register. • Completion of action plans to implement recommendations from audit concerns takes place within divisions and are reported to the CAC.	programme • Clinical audit procedure • Minutes of Trust Clinical Audit Committee • Minutes of Divisional Clinical audits groups
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; divisional and/or corporate committees; through the LIA programme; executive walk rounds; in line with the raising concerns (whistleblowing) policy; grievance procedure; through peer review; staff feedback sessions; and, staff surveys. The board is aware of any concerns raised by staff: the Workforce Committee; annual staff survey results; LIA programme updates and Executive walk rounds. Since early 2013, CGC minutes and the Board Quality Reports have included a section on concerns raised by staff. (see section 2b.5)	• Executive walk rounds • Staff Survey • LIA programme • Board reports
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?	Yes. • The clinical governance system in its entirety is designed to identify and address underperformance, to celebrate and share good practice, at whatever level of the organisation • Specific quality issues are addressed within divisions and highlighted as necessary through monthly Divisional reports to the Clinical Governance Committee following Divisional review • Specific updates on progress against Quality Account priorities are provided through the Clinical Governance Committee • The Board, through monthly and quarterly progress reports,	• Annual Staff awards with a focus upon quality • Minutes of CGC • Minutes of Performance Review meetings • Recognition schemes

	monitors progress against plan • 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 • Divisional performance is subject to regular review by the Performance Committee and escalated to the Trust Management Executive and Trust Board • Good performance at individual, team and service area are recognised through the OUH news, the LIA programme of awards and Divisional recognition schemes • The CGC terms of reference outline the committee's responsibility for monitoring compliance of clinical governance and where appropriate escalation of issues of concern where necessary for information and action • A document outlining the minimal requirements of clinical governance was circulated to all divisions and through the appropriate committees by the Medical Director, who also emphasised compliance • The Trust has a clear and updated policy for the Performance Management of individuals which meets clinical governance guidelines • A number of examples can be cited of the review of individual and service performance, undertaken on account of a potential quality concern • Staff appraisal, and in particular consultant appraisal, is designed to be data-rich. Developments in consultant appraisal in recent years have been rapid and an audit of appraisal / revalidation work offered significant assurance	• Minimal requirement of clinical governance • ToR for CGC • Performance Management Policy • CGC minutes • Reports relating to individual / service level concerns
3b.10. Does the organisation make	Yes.	• Waste in theatres

effective use of continuous improvement approaches?	The Clinical Governance function has devolved resources to individual Divisions with Clinical Governance Managers and clinical governance and risk practitioners. The key functions of these roles are to drive and support sustainable quality improvement initiatives across the Trust embedding continuous quality improvement at a Divisional Level. The Trust also has a service improvement team who 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 include an Emergency Department Paediatric Transfer Protocol. One division is currently implementing a Quality Circles approach to identifying and addressing issues (CSSD). There are also a number of individuals who have adopted continuous improvement methodologies and used these effectively in a number of projects such as First In First Out (FIFO) in Pharmacy. 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 small-scale projects.	• Anti – coagulation therapy • Emergency Department Paediatric Transfer Protocol • EMTA/MRC Divisional Nursing Quality Initiative • SIRI reports to CGC • • CCTDAP/CSS Divisional quality circle • Clinical Governance Organisational Structure
3c. Does the Board actively engage patients, staff and other key stakeholders on quality?	**Trust assessment (score):*GREEN / Score 0.0***	
	Response	**Evidence**
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**	The Board actively engages patients using a variety of processes outlined below: • Executive quality walk rounds. This scheme is based on the concept of "You said… We did…" and is intended to demonstrate this level of responsiveness.	• Executive walk rounds • Patient surveys • CQC surveys • Board papers

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?**	• Local patient surveys, the use of feedback forms and through its PALS service and the receipt of comments, commendations and complaints. Details are reviewed within the Divisions, the Quality Committee and the Board of Directors. • The "Friends and Family Test" has been successfully implemented by the Trust. • CQC surveys including outpatient surveys undertaken by the Picker Institute • The patient panel are actively involved in the development of patient information leaflets • The Learning Disability Partnership group are involved in overseeing the delivery of services to patients with learning disabilities. • The Board uses a wide range of approaches to bring patients views into the board through the use of patients' stories and the showing of DVDs at the quality committee. • Patient involvement in risk summit and peer review programme.	and patient stories • Patient panel forums • Patient engagement strategy • Peer Review • Risk Summits • Specific engagement events, both pan-trust and service specific
3c.2. How are quality outcomes made public and are they accessible regularly and include objective coverage of both good and bad performance?	• The Board's quality reports and quality accounts 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. • 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. • Quality account public engagement events are held with the aim	• OUH news • Chief Executive briefings • Public meetings • Public engagement events • Everyone Counts

	to review progress against last year's goals and to listen to patients thoughts about what the priorities for the forthcoming year should include. • Publication of Everyone Counts (outcomes in 10 surgical specialties, autumn 2013) with a prominent web presence, headline results and clear signposting to source reports	
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 tabled at each Board meeting 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. In the case of SIRIs these investigation reports are reviewed and reported to the CGC and a headline summary is provided in the quality report for the board. The Quality Committee receives summaries of each SIRI (at the point of recommendation to CCG for closure) and complaints data. The Committee begins its work with an in-depth patient story that will often include elements of poor experience and may have been developed from a complaint.	• Quality reports • Board minutes
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 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. 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. • The Trust is a national pioneer organisation in the Listening into Action (LIA) programme 2012/13. Staff commitment to quality is demonstrated and evidenced by the changes to patient safety, quality and experience that have arisen from clinical teams who have taken part in the 'Listening into Action – First Ten' scheme,	• Quality workshop • Staff survey results • Minutes of board meeting relating to discussion of staff survey results • LIA programme • Results of recognition scheme • Francis Briefing

	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. • A series of 'Francis Briefings' in 2013, following the publication of the Francis Report, were presented by the Assistant Medical Director and these were well attended by staff. Staff were encouraged to raise issues on an on-going basis, ideally through the management structure but also using other mechanisms as appropriate.	sessions
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 GPs and community care involved in the development of care pathways?** • **Are there discussions with GPs and community care to identify potential issues and ensure overall quality along the pathway?**	Yes, the board does actively engage key stakeholders on quality through the processes outlined below: • The External Stakeholder Engagement Plan describes the key existing and emerging stakeholders and tailored methods used for involvement. • The Integrated Business Plan includes details of stakeholder engagement including 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. • Quality meetings between the Medical Director, Chief Nurse, Director of Clinical Services and the CCG lead on Quality and GP representative. • GPs use the Datix incident reporting system to identify service problems. There are discussions between GPs and divisional clinical and managerial staff to resolve operational and clinical issues.	• External Stakeholder Engagement Plan • Monthly contract meetings • DTOC groups • Transfer of Information Task Force • Planned Care Programme Board • Maternity Services Liaison Committee • Health Overview and Scrutiny Committee

	• CCG/Patient Panel were consulted on quality strategy and quality account priorities.
	• A representative of the CCG attends Clinical Governance Committee
	• Monthly contract review meetings with CCGs include structured review of quality performance.
	• Joint working groups/task forces on issues impacting on quality e.g.
	  o DTOC groups
	  o Transfer of Information Task Force
	  o Planned Care Programme Board
	• Regular reports on performance (including quality) given to Community Partnership Network (multi-agency stakeholder group including community and patient representatives looking at the provision of health and social care in the north of the county).
	• Service-based groups e.g.
	  o Maternity Services Liaison Committee
	• Regular reports (including quality) given to the Health Overview and Scrutiny Committee.
	• The Trust visited each of the six localities of the Oxfordshire CCG to get feedback from GPs on, amongst other issues quality issues were discussed. The output of this was a proposed work programme, signed off by the Trust Management Executive on 25 April 2013. The work programme is now being progressed both internally and in collaboration with the CCG and GPs
	• The Trust held a well-attended public meeting in Banbury early in 2014
	• The Risk Summits and Peer Review have included patients, primary care clinicians and commissioners
	• There are regular governance meetings between officers of the trust and OCCG
		• OUH and GP liaison work programme

	• The Quality Account draft is consulted upon heavily, including with HOSC and Healthwatch Oxfordshire, with the Medical Director attending meetings of these organisations in order to ensure dialogue	
3c.6. Are the board clear about Governors' involvement in quality governance?	The Board anticipates governors will take an active interest in quality issues throughout the organisation as part of their scrutiny role over planning and priority setting. Working groups involving governors focussed on specific quality issues are likely to be established as required according to priorities in the future. Shadow FT members are invited to participate in work within the Trust.	• Governors presentation
3c.7. Is Quality performance clearly communicated to commissioners to enable them to make educated decisions?	Quality Performance is communicated to commissioners through a number of processes including: • The assistant director of quality from the Clinical Commissioning Group (CCG) attends the Trust's monthly Clinical Governance Committee meetings. • Monthly contract review meetings with CCGs include structured review of quality performance. • Monthly clinical governance meetings between Medical Director, Director of Clinical Services, Chief Nurse and the CCG. • Joint working groups/task forces on issues impacting on quality e.g. o DTOC groups o Transfer of Information Task Force o Planned Care Programme Board • Regular reports on performance(including quality) given to Community Partnership Network (multi-agency stakeholder group including community and patient representatives looking at the provision of health and social care in the north of the county) • Service-based groups e.g. o Maternity Services Liaison Committee • Regular reports (including quality) given to the Health	• Minutes of contract meetings • CGC minutes

	Overview and Scrutiny Committee.	
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	**Evidence**
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 future scores highlighted)** • **Where possible/appropriate, percentage compliance to agreed best-practice pathways** • **Qualitative descriptions and**	Yes, 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 • Stroke unit care	• Trust Board papers • BQR • Divisional Quality Reports.

commentary to back up quantitative information	• 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 (including FFT) • Incidents/SIRIs • CAS/NICE • Mortality (HSMR/SHMI and mortality review metrics) Reporting in relation to quality has been much improved and standardised over the course of 2013/14, with Divisional, Board and other quality reports fed by a single data warehouse (ORBIT) and making use of statistical process control methodologies in order to assist those reviewing data to draw statistically sound conclusions.	
4a.2 How does the board demonstrate that the selected metrics are; • **Linked to trust's overall strategy and priorities?** • **Covers all of the trust's major focus areas?** • **Are the best available and most useful to review?**	• Quality priorities consistent with the overarching quality strategy are identified, with the 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 for CCG contracts) and assess their value in driving and monitoring quality improvement for their patient groups. • A list of quality metrics for each service is developed by the services in order to engage all services in data quality issues and quality improvement work. • The Trust values information that can be widely benchmarked. This includes data provided through ATQD and by Dr Foster Intelligence. Work is on-going to improve our ability to benchmark with other peer groups including the Shelford Group. • The range of metrics covers all aspects of the three key domains	• IPR • Divisions and services area quality priority posters • Divisional quality report including local quality priorities

	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 and how information is reviewed throughout the trust by sub-committees, divisional leads and individual service lines up to Board level to form a pyramid effect?	• Data are reviewed and quality assured close to the point of origin before it is circulated 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. • The Trust has developed an Integrated Performance Report in order to provide the Board and Divisions with key information on quality, performance and finance in one location. • The online Datix reporting system for incident reporting and a range of other governance issues produce reports at divisional and for board level. • All 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. With current reporting, the same data feeds various reports in an automated fashion from a single central repository. • Quality information is reviewed through the established directorate, divisional and corporate reporting and committee structure forming a pyramid effect as outlined in the forwarding pages of this paper.	• Quality reports • Divisional quality reports • CGC minutes • Divisional governance meetings
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	• Overview of information on Orbit • Minutes of Clinical Audit

	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. • ORBIT data is readily available and offers a comprehensive view. • The Trust's new electronic patient record is bringing doctors closer to the data that subsequently determine payment and quality assessment. • Clinical coders hold regular sessions with clinical staff in various specialties in order to improve understanding and accuracy. • The "everyone counts" initiative by NHS England has been embraced by the Trust and the relevant results have been discussed at the Clinical Outcomes Review Group.	and Clinical Outcomes Review Group
4a.5. How is the board dashboard reviewed and updated for quality information to maximise its effectiveness?	The board dashboard or IPR is reviewed and updated in accordance to changes within the Trust. Quality information is reviewed and updated annually in accordance with the quality strategy; quality account; quality priorities; CQUIN targets; national priorities; Divisional priorities (as outlined in Divisional business plans and quality reports) to maximise its effectiveness and relevance. Additional items have been incorporated and other minor changes made for the IPR in 2014/15.	• Quality reports • Divisional business plans • IPR
4a.6 How does the board address areas lacking useful metrics? Does the board commit time and resources to developing new metrics?	• All Divisions and service areas were asked to identify two quality priorities and metrics for patient safety, patient experience and outcomes and effectiveness for 2013/2014. Quality priorities for each domain also formed part of the mandatory Divisional business plans for 2013 /2014. The Divisional clinical governance practitioners who have a joint corporate and divisional role work with each area to ascertain their priorities. Progress against these priorities is outlined in	• Divisional business plans • Standardised quality reports (divisional and board) • Performance Reports

	the monthly divisional quality reports reported to CGC. • The Board has driven the development of a data warehouse in order to collect quality data gathered from clinical environments in one place. This permits integration reporting of quality information, appropriate benchmarking and trend analysis. • External metrics available to the Board including Dr Foster and the ATQD inform the Board's approach to developing performance metrics and identifies where action is required as well as providing assurance. • The development of a standardised board quality report and divisional quality report templates.	
4a.7. What benchmarking activity does the Trust use to ensure that they compare favourably with peers?	• NHS Information Centre metrics on data quality are reviewed. • HSMR/SHMI 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 benchmarked via NRLS for acute trusts and ATQD 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 by HRG codes. • Comparative data made available PHSO • 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	• IPR • Benchmarking figures • ATQD • Cardiac surgery benchmarking data • Dr Foster reports to CGC • Specialist Commissioning Dashboards

	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. • Review of the outcomes from the national surveys for patients and staff. • Specialist Commissioning Dashboards.	
4a.8. Describe initiatives underway to improve quality information and subsequent decision-making.	Some of the initiatives underway to improve quality information and subsequent decision making are: • 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 for CQC outcomes. • Development of a refined dashboard for the Board with fewer key metrics (integrated board report). • Datix online reporting system was implemented throughout the Trust in Oct 2012 with modules for: clinical risk management; incident reporting; complaints; PALS; patient experience; legal services and clinical audit. • The development of a 'ward to board' quality report provides a minimal mandatory data set of quality metrics, which now form the basis of divisional quality reports, submitted to the Clinical Governance Committee. The Board Quality Report is based on the same data source	• Overview of Health assure • Internal audit of quality of data • Overview of Datix • Data Quality report
4b. Is the Board assured of the robustness of the quality information?	**Trust assessment (score): *AMBER/GREEN / Score 0.5***	
	Response	**Evidence**

4b.1 How is the board assured that on-going information is accurate, valid and comprehensive?	• The Trust has established a data quality group to test the robustness of 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; monitoring aspects of data quality and to benchmark; identifying areas for improvement, and provision of assurance to the relevant Board committee. • A new data quality assessment framework has been introduced. o All performance indicators in the integrated performance report are given a data quality assessment rating based on: ▪ The level of assurance available ▪ An assessment of data quality o These scores are then moderated by the Data Quality Group to which indicator owners must present their assessments and evidence. o Action required to improve the assessment is identified and monitored by the Data Quality Group. • External data quality audits form part of the Trust's annual audit programme. • A comprehensive data validation procedure has been established associated with the Electronic Patient Record.	• Data quality scoring card • Data Quality committee minutes • Data quality group agenda
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?	Yes, Each Division has established its own data quality group which reports into the corporate data quality group. A programme of divisional data quality audits has been introduced and a comprehensive data validation procedure has been established associated with the Electronic Patient Record.	• Minutes of Divisional data quality groups
4b.3 Is the clinical audit programme driven by national audits with processes for initiating additional audits as a result of	Yes. Drivers for the Clinical Audit programme are clearly outlined in the Clinical Audit Procedure	• Clinical audit procedure • Clinical audit

identification of local risks?		programme
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?	Yes, there is clear evidence that action to resolve audit concerns is taken within divisions through local audit groups. The action plans have clear owners and are reviewed in divisions; progress on selected audits is reported to CAC, CGC and Performance meetings.	• Minutes of local Divisional audit groups • Minutes of CAC • Trust audit committee
4b.5 Demonstrate how re-audits are undertaken to assess performance improvement in areas?	The importance of re-audit is made clear within the clinical audit procedure is outlined in the Clinical Audit Procedure. For many of the national clinical audits, re-audit is inbuilt. For other audit projects, the role for and timing of re-audit is considered when results are reviewed.	• Clinical audit procedure • CA reports
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. Some initiatives in place to improve coding include: • Various proformas in use / development to assist collection of appropriate coding • Charlson Index co-morbidities section added to General Medicine 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	• Coding meetings • Coding initiatives and proformas

	• Information Governance standards for clinical coding have attained level 3 this year • The Trust has appointed and trained a Clinical Coding Auditor to monitor and improve coding quality. • A Clinical Coding Trainer post has been identified as a necessary addition to the coding team and a member of staff is currently being trained to National Standards to achieve this. • Available benchmarking data (including the Audit Commission's PbR coding benchmarker) is reviewed to assess coding depth and other aspects	
4c. Is quality information being used effectively?	**Trust assessment (score): *AMBER/GREEN / Score 0.5***	
	Response	**Evidence**
4c.1. What benchmarking activity does the Trust use to ensure that they compare favourably with peers?	Multiple: Dr Foster Intelligence, ATQD, SHA/clinical network peer groups, NPSA six monthly analysis of incidents, National patient and staff survey outcomes, Shelford Group and National Clinical Audits, specialist commissioning. Audit Commission PbR benchmarker (coding). Active encouragement of staff to participate in CQC inspection / peer review.	• CGC minutes • Quality reports • Board reports • Participation by staff in CQC inspection
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. • Extensive work was undertaken in 2013 in order to standardise the template and core content of Divisional Quality Reports, and subsequently the Board Quality Report. • An integrated performance report (IPR) including quality measures is rag rated against national benchmarks and targeted levels of performance. For external comparison the Board and/or its sub-Committees also receives analysis of:	• IPR • Quality reports (Divisional and Board)

	• Contract monitoring reports from CCG Commissioners. • ATQD • Dr Foster Intelligence.	
4c.3. Is the quality information being used the most recent and relevant?	Yes, the Board receives a monthly quality report and an Integrated Performance Report. These contain the most recent data e.g. data collection point ending five weeks previous. Directors, senior clinicians and managers can also access the Trust's '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 is a range of performance measures identified annually by the commissioners. Quality information provided by services derives from both national and local quality priorities based on a needs analysis. The Datix system provides services with up to date information relating to incidents.	• Quality reports • IPR • Example of information from Datix
4c.4. Is the Trust able to demonstrate how reviewing the information has resulted in actions which have successfully improved quality performance?	Yes. For example; • Reduction in readmission rates following primary CABG (coronary artery bypass graft) surgery. • Reduction in LOS following cardiac pacemaker insertion • Medicines reconciliation within 24 hours of admission • Data from clinical audit in diabetes led to a risk summit and significant investment / intervention • Good performance in relation to infection control (MRSA, C Diff, surgical site infections) • VTE risk assessment rates are much improved The Board also focused on key areas of quality in 2013 relating to falls, pressure ulcers and infection, which reduced the incidence compared to previous years.	• Readmission rates for primary CABG • LOS data for Cardiac pacemaker insertion • Medicines reconciliation data • Infection control reports
4c.5 Is quality data for the highest priorities metrics available on demand?	Yes, ORBIT is the Trust's 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. The IPR is available at Board and Divisional level and provides metrics on quality	• Example of IPR • Example of information available on

	data at the highest level.	Orbit
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.	• Quality reports • HSMR and SHIMI data
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 (notably the Data Quality Group and the Health informatics Committee). It is cross-referenced through the Divisions.	• CGC minutes • Divisional Governance meetings • QC minutes • Performance review meetings

Appendix 1 / Abbreviations

Term	*Meaning*	*Term*	*Meaning*
AC	*Audit Committee*	**EMTA**	*Emergency Medicine Therapies and Ambulatory*
A&E	*Accident and Emergency*	**EPR**	*Electronic Patient Record*
BAF	*Board Assurance Framework*	**ESR**	*Electronic Staff Record*
BGAF	*Board Governance Assurance Framework*	**FT**	*Foundation Trust*
CA	*Clinical Audit*	**FTN**	*Foundation Trust Network*
CAC	*Clinical Audit Committee*	**FIFO**	*First in First Out*
CABG	*Coronary Artery Bypass Grafts*	**GP**	*General (Medical) Practitioner*
CAS	*Central Alerting System*	**HRG**	*Healthcare Resource Group*
CCAD	*Central Cardiac Audit Database*	**HMR**	*Hospital Mortality Ratio*
CCG	*Clinical Commissioning Group*	**HSMR**	*Hospital Standardised Mortality Ratio*
CCTDAP		**IBR**	*Integrated Board Report*
CEO	*Chief Executive Officer*	**IGST / IGT**	*Information Governance Toolkit*
CGC	*Clinical Governance Committee*	**IPR**	*Integrated Performance Report*
CIP	*Cost Improvement Plan*	**IT system**	*Information Technology System*
CQC	*Care Quality Commission*	**KPI**	*Key Performance Indicator*
CQUIN	*Commissioning for Quality and Innovation*	**KPMG**	*Name of a company that provides Audit, Tax and Advisory services*
CRM	*Clinical Risk Management*	**LIA**	*Listening in Action*
CRR	*Clinical Risk Register*	**LINKS**	*Local Involvement Networks*
CSU	*Clinical Services Unit*	**LOS**	*Length Of Stay*
CCTDAP	*Critical Care Theatres Diagnostics and Pharmacy*	**MDO**	*Medical Directors Office*
DATIX	*Company name for Electronic Incident Reporting system used at OUH*	**MRSA**	*Multi Resistant Staff Aureus*
DH	*Department of Health*	**NED**	*Non-Executive Director*
DOLS	*Deprivation of Liberty Safeguards*	**NHSLA**	*NHS Litigation Authority*
DToC	*Delayed Transfer/s of Care*	**NICE**	*National Institute for Health and Clinical Excellence*
DVD	*Digital Video Disc*	**NPSA**	*National Patient Safety Agency*
ED	*Executive Director*	**NHS**	*National Health Service*

Term	*Meaning*	*Term*	*Meaning*
NRLS	*National reporting and Learning system*	**SHA**	*Strategic Health Authority*
ORBIT	*Oxford Reporting Business Intelligence Tool*	**SHDS**	*Supported Hospital Discharge Service*
ORH	*Oxford Radcliffe Hospitals NHS Trust*	**SHMI**	*Summary Hospital Mortality Indicator*
OUH	*Oxford University Hospitals NHS Trust*	**SIRI**	*Serious Incident Requiring Investigation*
PACS	*Picture Archiving and Communication System*	**SPC**	*Strategic Planning Committee*
PALS	*Patient Advice and Liaison Service*	**TAG**	*Technologies Appraisal Group*
PCT	*Primary Care Trust*	**TME**	*Trust Management Executive*
PHSO	*Parliamentary and Health Services Ombudsman*	**VTE**	*Venous Thromboembolism*
PM	*Performance Management*	**WHO**	*World Health Organisation*
PROMS	*Patient Reported Outcome Measures*		
QC	*Quality Committee*		
QGF	*Quality Governance Framework*		
QIPP	*Quality, Innovation, Productivity and Prevention*		
QIA	*Quality Impact Assessment*		

NICE	*National Institute for Health and Clinical Excellence*
NPSA	*National Patient Safety Agency*
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