

# Quality Governance Framework 2014/15

Liverpool Heart and Chest Hospital NHS

Foundation Trust

FINAL - Phase 2 Report



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## 1. Context

MIAA recently reviewed the Trust's quality governance arrangements, assessing the Trust against the four domains, ten questions and associated good practice indicators in Monitor's Quality Governance Framework (QGF).

We presented an interim report to the November 2014 Quality Committee setting out the Trust's self-assessment, our findings, our interim rating of the evidence and recommendations for areas of actions. At that time, using Monitor's scoring methodology (see Appendix A) we provided an overall interim score of 4. Monitor expects Foundation Trusts to self-assess against their QGF and maintain a score of 3.5 or less.

Recognising that the findings in our interim report represented a snapshot in time and that the Trust is strengthening its governance on an ongoing basis, senior management asked us to carry out an additional phase of work in December 2014.

In this next phase of the work, senior management provided us with evidence to show how they consider the Trust has delivered on key action points in the interim report. We used interviews and review of evidence to revisit and potentially rescore the following four key questions in the framework:

- Does quality drive the Trust's strategy?
- Does the Board promote a quality focused culture throughout the Trust?
- Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
- Is the Board assured of the robustness of the quality of information?

Given that this is a targeted review we have not revisited the whole of the Trust's self assessment or confirmed that the good practice examples included in the interim report are still in place, unless we were told otherwise. This means that we have only provided an update for events, changes and circumstances for those areas we have reviewed since we completed our fieldwork in September 2014.

In line with the approach set out in our Terms of Reference we have reviewed a number of key documents and carried out a range of internal interviews. More detail on these areas is set out in Appendix B.

## 2. Executive Summary

The table below details MIAA's score in September 2014 and the updated score following the targeted update in December 2014 – the highlighted boxes show the four questions we have revisited and \* indicates questions we have not revisited.

| Monitor's Framework questions   | Quality Questions – updated      | Governance – updated      | Interim score Sept 2014 | Updated score Dec 2014 | Interim score at Sept 2014 | Updated score at Dec 2014 | Change |
|---|----------------------------------|---------------------------|-------------------------|------------------------|----------------------------|---------------------------|--------|
| 1A Does quality drive the trust's strategy?   |                                  |                           | 0.5                     | 0                      | Amber                      | Green                     | ↑      |
|   |                                  |                           |                         |                        | Green                      |                           |        |
| 2B Does the board promote a quality-focused culture throughout the trust?   |                                  |                           | 0.5                     | 0.5                    | Amber                      | Amber                     | ↔      |
|   |                                  |                           |                         |                        | Green                      | Green                     |        |
| 3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? |                                  |                           | 1                       | 1                      | Amber                      | Amber                     | ↔      |
|   |                                  |                           |                         |                        | Red                        | Red                       |        |
| 4B Is the board assured of the robustness of the quality information?   |                                  |                           | 0.5                     | 0.5                    | Amber                      | Amber                     | ↔      |
| <b>Monitor's Framework questions*</b>   | <b>Quality Questions – other</b> | <b>Governance – other</b> |                         |                        |                            |                           |        |
| 1B Is the board sufficiently aware of potential risks to quality?   |                                  |                           | 0.5                     | 0.5                    | Amber                      | Amber                     |        |
|   |                                  |                           |                         |                        | Green                      | Green                     |        |
| 2A Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?               |                                  |                           | 0.5                     | 0.5                    | Amber                      | Amber                     |        |
|   |                                  |                           |                         |                        | Green                      | Green                     |        |
| 3A Are there clear roles and accountabilities in relation to quality governance?  |                                  |                           | 0.5                     | 0.5                    | Amber                      | Amber                     |        |
|   |                                  |                           |                         |                        | Green                      | Green                     |        |
| 3C Does the board actively engage patients, staff and other key stakeholders on quality?                                      |                                  |                           | 0                       | 0                      | Green                      | Green                     |        |
| 4A Is appropriate quality information being analysed and challenged?  |                                  |                           | 0                       | 0                      | Green                      | Green                     |        |
| 4C Is quality information used effectively?   |                                  |                           | 0                       | 0                      | Green                      | Green                     |        |
| <b>TOTAL</b>  |                                  |                           | <b>4</b>                | <b>3.5</b>             |                            |                           |        |

## Summary of findings

Following our interviews and review of evidence we have re-assessed and re-scored the Trust's position on four out of the ten questions using Monitor's scoring methodology. Our interpretation of the evidence and our judgement in comparing the Trust to Monitor's example good practice indicators has resulted in the score moving from 4 to 3.5.

We have seen that action has been taken on all the priority areas identified in the Interim Report. In particular the Clinical Quality and Improvement Strategy (CQIS) has now been finalised and shared across the Trust. On this basis we have re-scored key question 1A as green. Feedback from our interviews suggests that Board engagement with clinical leads and clinical members of groups is good but could be better for those clinicians that do not routinely come into contact with the Board.

For the other three key questions, although we have seen evidence that progress has been made and some quick wins achieved, the scores have stayed the same and the conclusion remains that many of the actions are as yet neither embedded nor fully implemented.

For questions 2B and 4B, these remain at the previous amber-green assessment– there is evidence of robust action plans that management will deliver green performance within a reasonable time frame.

For question 3B this remains at the previous amber-red assessment - based on the work we have done, there is a risk that there is limited capacity to deliver the action plans for risk management and people/OD changes within a reasonable time frame. Whilst acknowledging that action plans have been generated, they are in the early stages of development and the Trust will need to recruit to posts in any new approved structures to create the capacity to deliver the changes.

The risk to the Trust from nursing and medical staffing shortages both in the short and medium to long term has been recognised in the Board Assurance Framework. Staff we spoke to told us that recent initiative such as the changes in the risk register format, the PDR

### Quote from interview

"Big initiatives take senior staff away from clinical areas and impact on the skill mix in wards etc. Recruiting to fill the gaps is very challenging."

process and the growing training requirements are all impacting on the time that staff spend with patients. This creates additional pressure to backfill – this can be expensive and often the Trust finds it difficult to meet all the temporary staff needs.

Whilst there are many very good initiatives running in the Trust, all with the aim of further improving quality

### Monitor requirements

A score of 3.5 means that overall the Trust is able to demonstrate that it meets Monitor's requirements for quality governance.

governance, it may be in the Trust's best interests to have a stock-take of the initiatives, assess the impact of them on staff time and attach priorities to them. This should help reduce the perception of initiative overload among staff groups.

This report contains a summary of our findings and gives an updated score based on the additional evidence provided. This Phase 2 report is not as comprehensive as the Interim Report and should be read in conjunction with that report.

### **Priority recommendations:**

The main recommendations from this update are:

- Have a stock-take of the current initiatives, assess the impact of them on staff time and attach priorities to them. As part of this process, the Board needs to be clear on how the Trust can measure the return from its investment in new systems and processes.
- Decide on which recommendations from the Risk Management Review to implement. The changes may require extra capacity and the Trust will need to ensure that there are appropriate transition arrangements should there be a significant restructuring of the risk function.
- Complete the People and OD Strategy and recruit to posts in any new approved structures to create the capacity to deliver the changes. In drawing up action plans the Board should determine the level of performance that would give confidence that they are supporting staff to perform reliably in their roles.
- Consider increasing the number of informal Board member visits to the "shop floor" as a way of building relations with clinicians who do not routinely come into contact with the Board ie are not clinical leads or sit on groups.

### **Detailed findings**

More detailed observations for each of the key questions we revisited are set out below:

#### **1A Does quality drive the trust's strategy?**

- ✓ The Board approved the CQIS (2014-2017) at its November 2014 meeting. The approved CQIS has been cascaded throughout the Trust and also shared with governors.
- ✓ The Board has had assurance that there are action plans to reduce the incidence of sepsis in the Trust. The Medical Director is working with the Trust lead for sepsis on the priorities to be addressed and an update will be presented to the Board at its meeting in January 2015.

- ✓ The Executive Team carried out two further roadshows to communicate the Trust's key objectives which included quality goals. The roadshows were well attended by clinicians from both the medical and surgical divisions.
- ✓ The nursing staff we spoke to felt fully engaged in the Trust quality agenda. The clinical staff we spoke to would prefer more of an emphasis on outcomes rather than processes but accepted that they have had the opportunity to inform the quality priorities and recognise that some of the quality indicators are driven by external factors.
- ✓ As part of the annual refresh of the CQIS going forward the Director of Nursing intends to attend audit days and other events with the aim of finding more effective ways of engaging with clinicians. Feedback from our interviews suggests that Board engagement with clinical leads and clinical members of groups is good but could be better for those clinicians that do not routinely come into contact with the Board.

We have scored this key question as green which is an improvement from the amber-green score in September. Based on the evidence provided to us the Trust meets many elements of good practice and there are no major omissions.

## 2B Does the board promote a quality- focused culture throughout the trust?

- ✓ There has been a push to complete appraisals and the number of completed appraisals reported to the Board in the November dashboard was 83% (up from 68% the previous month).
- ✓ Attendance at mandatory training at 94% is now just below the target of 95%.
- ✓ The Trust has recently introduced a daily safety huddle where all key managers come together to provide an update in their clinical areas eg beds and staffing. Feedback to us suggests that this initiative has been a great success. However the timing of the huddle means that it is difficult for clinicians to attend.
- ✓ Feedback to us suggests that the "You Said, We Did" communications have been well received by all staff groups.
- ✓ The results of the culture survey have now been analysed and an update on actions reported to the Board. Work has started in those clinical areas where the culture survey suggested there was the greatest scope for improved staff engagement.

We have not changed the scoring for this key question as the previous amber-green assessment remains – there is evidence of robust action plans that management will deliver green performance within a reasonable time frame.

### 3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?

- ✓ The external risk review report has been received and an action plan has been developed. The Board will be reviewing both of these documents on 16th December 2014. As an immediate action, risk management has been added to the portfolio of the Director of Research and Informatics. The aim is to have a very senior manager have focus on building the Board and Trust's capacity to manage and anticipate risk.
- ✓ The Board will take part in a workshop at its development day in December with the intention of determining the risk appetite of the Trust. It is the intention that following this meeting work will follow to develop an effective risk register which will support regular reporting and provide greater clarity on the top risks.
- ✓ The top ten corporate risks will be shared with the Board at its next meeting. The intention is to have this as a regular item on the agenda.
- ✓ Evidence from the minutes of the November 2014 Board meeting record that the Board discussed and confirmed the process that would be in place to support the quality impact assessment of 2015/16 CIPs as part of the annual review process.
- ✓ The Board has had an update on the development of the Trust's People and OD Strategy at its November meeting. The update sets out the key workstreams and focus for the strategy. The final strategy will be presented to the Board in February 2015.
- ✓ Feedback to us suggests that the Trust has responded in a really positive way to address the risks raised by the likely shortfall in junior doctor posts for the next rotations. Work is underway to look at an alternative working model for surgery and to ensure that a business continuity plan is in place for February 2015.

We have not changed the scoring for this key question as the previous amber-red assessment remains. Whilst action plans have been developed to address perceived shortfalls the action plans remain in the early stages of development and, based on the work we have done, there is a risk that there is limited capacity to deliver these within a reasonable time frame.

Further detail on reasons for not changing the score are set out below:



- The proposals from the recent risk review contain a number of suggestions for how the Trust can develop its risk management arrangements. Whilst the Trust may be sighted on the improvements it wishes to make, the plans are still under development and could require a significant investment in risk management capacity and capability.

It will be a challenge to deliver the improvements suggested in a reasonable timescale. In addition the Trust will need to ensure that there are appropriate transition arrangements should there be a significant restructuring of the risk function.

- One of the key objective of the revised non-medical appraisal process is “to introduce a consistent and well regarded clinical performance management process that is linked to both individual performance and Trust-wide values and objectives.”

It is clear from our interviews and our review of the documentation that the revised approach is not currently fully embedded and further work is needed eg include a reliable method for measuring performance against objectives such as SMART. It will be interesting to see whether the results of the 2014 survey, for the appraisal related indices, corroborates the views given to us more widely across the Trust.

Other enhancements to the appraisal process that are needed include the requirement for appraisal outcomes to be moderated to ensure consistency across the Trust.

- The People and OD Strategy is due to be presented to the Board for approval in February 2015. Key priorities will be:
  - Organisational culture
  - Collective leadership
  - Staff and stakeholder engagement
  - Workforce planning and
  - Ensuring policies, structures and processes are fit for purpose.

This is an ambitious project that will require investment and change in the HR function. The structure for the OD function has been approved but the structure for the workforce function is not yet approved. It may take some time to recruit to the new structures.

The proposed PMO function is expected to have a big influence on key workstream areas and manage the risk that different elements of intervention are fragmented and delivered in isolation. The PMO is still being set up and will not be fully functioning until all posts are filled.

- The level of sickness absence has increased in recent months. A review is ongoing to assess if this is a genuine increase or whether it is linked to changes in how sickness is recorded now that the HR function has been brought back in house.

#### 4B Is the board assured of the robustness of the quality information?

- ✓ An action plan for implementing the new data quality assessment system has been prepared. The plan sets out key objectives and for each objective there is an action and details of person responsible and timescale for delivery. A new data quality scoring system has been developed and is being trialled on a small sample of indicators.
- ✓ The data quality improvement programme is being managed by the Business Intelligence Group (BIG), which will report into the Clinical Systems Authority. The project is in its early stages and as yet there have been no reports from the BIG
- ✓ An external independent clinical coding audit is planned for January 2015. A further external clinical coding audit is taking place as part of the PbR assurance framework in February and March 2015, it will be carried out by Capita CHKS on behalf of Monitor.

We have not changed the scoring for this key question as the previous amber-green assessment remains – there is evidence of robust action plans that management will deliver green performance within a reasonable time frame.

#### Next steps

This Phase 2 report will be considered by the Quality Committee which has a role in providing an independent and objective view to the Board of the Trust's compliance with Monitor's Quality Governance Framework.

The scores are our assessment of the Trust's position against the good practice examples issued by Monitor and are based on our interpretation and judgement of the evidence provided. It is ultimately the Board's responsibility to assure itself of compliance with the Quality Governance Framework and communicate in its Annual Report, how the Trust has had regard to the framework in arriving at its overall evaluation of the organisation's

performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality.

In addition to responding to the priority recommendations in this Phase 2 report the Board should revisit the areas for enhancement in our Interim Report, in particular we re-iterate that the Board should seek assurance that the changes to the governance structures at and below Board level are embedded throughout the Trust and are having the desired effect of delivering Trust-wide quality services.

## Appendix A: Monitor's Scoring Methodology

### Risk rating and scoring the self-assessment

The scoring methodology is set out in the table below:

| Monitor's Quality Governance Framework Scoring Methodology |       |         |  |  |
|--|-------|---------|--|--|
| Risk Rating  |       | Scoring | Definition   | Evidence   |
| Green  |       | 0.0     | Meets or exceeds expectations.   | Many elements of good practice and there are no major omissions.   |
| Amber  | Green | 0.5     | Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable time frame. | Some elements of good practice, has no major omissions and robust action plans to address perceived short falls with proven track record of delivery.  |
| Amber  | Red   | 1.0     | Partially meets expectations, but with some concerns on capacity to deliver within a reasonable time frame.                      | Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in an early stage of development with limited evidence of track record of delivery. |
| Red  |       | 4.0     | Does not meet expectations   | Major omission in Quality Governance identified. Significant volume of action plans required and concerns on management capacity to deliver.   |

This scoring methodology is detailed in Monitor's "Applying for NHS Foundation Trust Status – Guide for Applicants."

## Appendix B: Scope of work and approach taken

As defined in our terms of reference we reviewed the evidence in place to demonstrate progress against selected good practice indicators relating to the following areas for action identified in the interim report:

- Finalising the Clinical Quality and Improvement Strategy (CQIS) and sharing this across the Trust
- Embedding risk management
- Improving data quality assurance
- Delivering improvements in people management, organisational development and culture across the Trust.

It was outside the scope of this review to provide a view on whether the changes to the governance structures at and below Board level are embedded throughout the Trust and are having the desired effect of delivering Trust-wide quality services.

Our work consisted of the following:

- Reviewing and evaluating the evidence provided, these included:
  - Draft Board of Directors minutes from the November meeting
  - Action Plan against the Recommendations Made in the Review of Risk Management Arrangements by PM Governance, November 2014
  - Improving Data Quality Action Plan
  - Development of the Trust's People and OD Strategy Board paper
- Interviews with the following staff:

| Name           | Title  |
|----------------|--|
| Sue Pemberton  | Director of Nursing and Quality              |
| Lucy Lavan     | Associate Director of Corporate Affairs      |
| Mark Jackson   | Director of Research and Informatics         |
| Joan Mathews   | Head of Governance - Emergency Planning Lead |
| Janet Doran    | Head of Workforce                            |
| Stephen Colfar | Head of Education & Corporate Learning       |
| Tina Kenny     | Ward Manager – Elm Ward                      |
| Dr John Morris | Consultant Cardiologist                      |
| Mr Mark Pullen | Clinical Lead for Cardiac Surgery            |

- Attending and observing a Quality Committee meeting. We have provided feedback to the Director of Nursing and Quality in a separate note.