Quality Governance and Assurance
Strategy 2014 - 2017
Engage and Cascade
Assure and Escalate
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**Definitions:**
Monitor defines quality governance as: “…the combination of structures and processes at and below board level to lead on trust-wide quality performance including:
- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best-practice
- identifying and managing risks to quality of care"
Key Messages from this Strategy

The Core Elements of the Strategy:

<table>
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QUALITY GOVERNANCE AND ASSURANCE IMPLEMENTATION

Compliance with standards & statutory obligations
Continuous assurance and improvement in quality and performance

Context of the Strategy

This Quality Governance strategy is an overarching strategy which outlines the plan for the continued development of Quality Governance at University Hospital Southampton NHS Foundation Trust (UHS). It sets out the objectives and scope of Quality Governance within the Trust. It also reflects the internal and external needs and pressures that have Quality Governance implications for the Trust.

The strategy identifies what ‘Quality Governance’ means for the Trust, gives clear direction and a shared vision for how we ensure this is a priority, at all levels in the Trust. It also outlines how Quality Governance is organised within the Trust as part of a whole-system approach to improving standards and protecting the public from unacceptable standards of care.

To ensure a coherent and integrated approach, this strategy draws together the following key Trust Strategies:

- Patient Safety Strategy
- Patient Experience Strategy
- Patient and Public Involvement Strategy
- Clinical Effectiveness/Outcomes Strategy
- Regulation and Assurance (including Risk Management)

UHS’s 2020 Vision is to be a world-class centre of clinical and academic achievement, where staff works together, to ensure patients receive the highest standards of care. Quality Governance is at the heart of such vision, ensuring that systems and processes are in place to assist staff to deliver quality care.

In High Quality Healthcare for All, Darzi states that quality is the organising principle for the NHS with emphasis on patient safety, patient experience and the effectiveness of care. “High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual.” This strategy details how these fundamental aspects of quality care will be achieved.

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1 High Quality Care for All (2008) Department of Health
Introduction

What is Assurance?

Assurance is part of good governance practice. It is about the Trust Board (or its sub-committees) being provided with accurate and current information about the efficiency and effectiveness of its policies and operations, and the status of its compliance with the statutory obligations in order for Board members to be confident that the desired level of quality is being delivered in the development and delivery of Trust services and that objectives are being met.

What is Quality Governance?

Quality governance is defined as the combination of structures and processes at and below board level to lead on Trust-wide quality performance including:
- ensuring accountability for quality and that required standards are achieved
- investigating and taking action on sub-standard performance
- identifying, sharing and ensuring delivery of best-practice
- identifying and managing risks to quality of care
- ensuring the organisation’s culture supports engaging effectively on quality to plan and drive continuous improvement

The aim of Quality Governance is to provide the Trust Board with assurance of effective and sustainable management of quality throughout the Trust.

The foundation of this Quality Governance and Assurance Strategy is based around the four domains of Monitor’s Quality Governance Framework and ensuring the organisation measures itself against these basic principles:

Strategy
- quality drives the Trust strategy
- the Board is aware of potential risks to quality
- the values of the NHS Constitution take priority, with putting patients first the overriding ethos of everything we do

Capabilities and culture
- the Board have the leadership, skills and knowledge to ensure delivery of the quality agenda
- the Board promote a quality-focused culture throughout the Trust

Processes and structures
- there are clear roles and accountabilities in relation to quality governance
- there are clearly defined, well understood processes for escalating and resolving issues and managing quality performance
- the Board actively engage patients, staff and other key stakeholders on quality

Measurement
- appropriate quality information is analysed and challenged
- the Board are assured that the desired level of quality is being delivered in the development and delivery of Trust services
- the robustness of the quality information and assurance quality information is used effectively
Some of the actions we will take to ensure our continual compliance with these principles include:

- Further development and promotion of our values and behaviours and a culture of openness and honesty
- Enhancing our Board development programme
- Drawing the quality governance streams of work together to help the organisation function more effectively
- Embedding quality and accountability for quality in everything we do and striving for continual improvement
- Putting patients first and involving them in how their care is delivered and how services are designed
- Ensuring patients receive treatment that is safe and clinically effective
- Assuring quality governance and management of our risks is subject to rigorous challenge
- Strengthening our analysis and use of quality data and information
- Refining our escalation and assurance systems and processes

As an organisation we will also engage the wider health economy and work in partnership with our commissioners, other providers, the public, patients and other external agencies to achieve the aims of this strategy. The foundation of our strategy will be ensuring the lessons from the Francis Report, which reviewed the failings at Mid Staffordshire NHS Foundation Trust, and the Government’s response, outlined in their report “Hard Truths”, are embedded in our organisation and our culture.

This strategy is not a stand-alone document but is intrinsically linked to our longer term corporate vision, strategic/annual plans, operational and business plans. Further detail of our quality commitment is contained within these documents and our Quality Account.

What do we want to achieve?

As a Trust we are aiming to achieve:

- Improvement of the patient experience and excellent clinical outcomes for patients with a culture of continuous improvement in order to both reduce variation and improve overall quality of care.
- Doing the right things in the right way, innovating and ensuring our teams base their practice on the best available evidence.
- A patient centred and patient led approach to care, treating patients courteously, listening to them, keeping them informed and involving them in decisions about their care (no decision about me without me – DH 2010).
- The creation of an environment of openness, honesty and candour in which problems are prevented, detected quickly and addressed firmly.
- The delivery of services developed in response to feedback from patients, the public and other key stakeholders such as service commissioners and HealthWatch.
- Promotion of a culture of safe, compassionate care with a reduction of the risk from clinical errors and adverse events, as well as a commitment to learn from mistakes and share that learning both across the Trust and externally.
- An environment which is safe for both patients and staff and supports their needs and well-being.
- Assurance that the Trust is well managed, well led and compliant with regulatory requirements.
- Strong leadership, accountability and engagement of our staff throughout the organisation, both clinical and non clinical.
- Consistently providing care which is evidence based, safe, effective and adheres to best practice.
- The collation of data which is robust, well analysed and used effectively.
Clearly defined, well understood processes for reviewing the assurance of, and escalating and resolving, quality issues and performance.
Robust mechanisms for adapting to the changing health landscape.

The Trust's Strategic Objectives
In line with the above the Trust has set three strategic objectives, these are:
- Trusted on quality
- Delivering for taxpayers
- Excellence in healthcare

The Trust’s values have been identified as:
- Patient first
- Working together
- Fresh thinking

Key Objectives of this Strategy
This strategy details the key objectives for:
- Quality Governance including Risk Management and Regulatory Assurance
- Patient Safety
- Patient Experience
- Clinical Outcomes and Effectiveness
- Our Patient Improvement Framework (PIF)

Quality Governance Objectives
Continue to set a clear direction for the implementation of Quality Governance through realistic goals that take into account the organisational context and strive for continual improvement:

➢ Strategy - Clear direction and realistic goals
Ensure the Trust’s governance and risk management framework continues to be fit for purpose at all levels - being clear, understandable and seamless, whilst supporting continuous assurance and quality improvement as well as risk minimisation.

Continue to develop and deliver the Trust’s Patient Improvement Framework and the work streams encompassed within it.

Deliver continual compliance with the Care Quality Commission (CQC) registration, regulations, standards and inspections (achieving a rating of ‘Good’ of above) and with Monitor’s Quality Governance requirements.

Maintain and continually improve on the Trust’s assessments in relation to other external accreditations, inspections and peer reviews.

➢ Capabilities and Culture – leadership and quality focus
Continue to ensure that explicit and robust accountability arrangements are in place and effective at all levels of the Trust

Demonstrate that our Board have the leadership, skills and knowledge to ensure delivery of the quality agenda and promote a quality-focused culture throughout the Trust.

Increase the number of patient representative and special interest groups we engage with and inform – we will set up and keep live, a data base of PPI events and groups to ensure we reach

NHS Values:
- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving Lives
- Everyone counts
as many members of the public as possible.

Build on our research and commercial initiatives to enhance our services to our patients.

Work with our Divisions on developing a sustainable improvement culture by developing the skills of staff in reviewing quality.

➤ **Processes and Structures – accountability, escalation and resolution**

Work with key stakeholders such as commissioners, regulatory bodies, patients and the public to ensure engagement with, and accountability to, those who pay for and use our services.

Further develop clearly defined, well understood processes for reviewing assurances and escalating and resolving quality and performance issues.

Continuing to enhance printed and web based information about our services and Patient and Public Involvement activities.

Regularly review the effectiveness of our committee structures and policy management system to ensure they are fit for purpose.

➤ **Measurement - monitoring improvements and intelligent information**

Monitor improvements through the further development of both standard-based and outcome based indicators across the Trust, e.g. the use of clinical metrics and use these outcome measures to inform us, our patients, the public and commissioners on our performance.

Ensure collation of intelligent information and data which is robust, well analysed and used effectively in the production of regular reports and identification of ‘hot spots’ to support decision-making and effective operation of the Trust at all levels.

Use our clinical audit programme as a force for improvement across all services (Mortality rates: use Observed (crude) Mortality rates, Hospital Standardised Mortality Ratios (HSMR), Summary Hospital Level Mortality Indicators (SHMI), feedback from Dr Foster, Mortality Review Panel and effective Morbidity & Mortality meetings provide an important aspect of outcome measurement and of driving improvement).

Develop Quality Reviews (based on the Keogh and new CQC inspection regime methodology)

Promote and enhance our involvement in external audit/peer review/ benchmarking initiatives.

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**Governance annual work programme – in 2014/15 we will:**

- focus on maintaining and enhancing the safety and effectiveness of our services and our patients’ experiences and ensure compliance with the new CQC regulations and Monitor’s Quality Governance and Well Led Framework requirements
- make further improvements in the systems we have introduced for our policies management and ensure procedural documents are user friendly and updated in a timely manner
- continue the development of the processes, scrutiny and monitoring systems for the accreditations and inspections taking place throughout the organisation to ensure our services meet the standards of our regulators, reviewers and accreditation bodies and ensure any improvements to compliance are addressed promptly
• review our risk management and assurance systems regularly to ensure they are robust
• develop risk and quality profiles for our Divisions – so they know what they are doing well, what needs improvement and understand their accountability to continuously monitor and improve
• continue to adapt our systems and practices to meet the needs of regulatory and legislative changes and developments
• use both internal and external learning and benchmarking to ensure continuous quality improvement
• publish further information on our services and performance in our annual Quality Account and our Annual Plan
• tackle and report on (through our Patient Improvement Framework - PIF) the areas our staff and patients say they feel we could improve further.
• update the priorities and metrics in our Clinical Quality Dashboard
• build on our Quality Governance Framework and further develop our Assurance and Escalation processes to support further embedding of our framework and review our current evidence to ensure our assurances are robust
• review our quality governance committee structure to ensure it remains efficient, effective and appropriate
• continue to ensure our culture, systems and practices evolve in line with the lessons learned from the Francis, Berwick and Hard Truths reports
• enhance our Duty of Candour practices to further develop our culture of openness, honesty and transparency
• make it easier to comment or make a complaint about our services
• Ensure each patient has an identified senior clinician in charge of their care
• produce an annual Quality Governance Report which details achievement against these objectives.

Risk Management Strategy

A key component of Quality Governance and Assurance is sound risk management practice and the Trust has set clear risk management objectives to support the achievement of the Quality Governance Strategy objectives.

The Trust is committed to providing high standards of patient centred care in all settings. All services are required to focus on patient safety, experience, outcomes and quality of care whilst acting with responsibility within the financial and performance framework of the Trust.

Through a coordinated approach within the organisation to the management of risk outlined in our Risk Management Policy and associated policies and procedures, the aim is to achieve the following objectives:

Risk Management Objectives
How quality governance is applied in practice

In March 2007 the UHS Trust Board first agreed a Patient Improvement Framework (PIF) and this framework forms the basis of the Quality Governance Framework. The PIF is updated and reviewed annually and the most recent PIF is shown on page 12.

The PIF focuses on patient safety, patient experience, patient clinical outcomes and performance/assurance. This common theme is also mirrored in the Trust's committee structures and high level reporting practices. This integrated approach ensures that staff understanding of the Quality Governance framework, operationalised through the PIF, is embedded throughout the organisation and reflected in the Trust's dashboards and key performance indicators.

Supporting the main pillars of the PIF are the associated work streams which are outlined on pages 16 to 19.

To ensure our strategies, linked to our work streams, form the basis of practice throughout the organisation they are supported by policies, procedures, guidelines and the terms of reference through which our committees operate, in order to achieve the goals identified in this document.

The diagram overleaf shows the Trust's Governance Committee structure and the Flowchart on page 10 demonstrates how our assurance reporting processes flow from ward to board and board to ward.
Committee Structure

QGSG - is responsible for the ratification of most Trust wide Policies through PRAM.

Please Note: Some of the Feeder/sub groups illustrated here have additional working groups or task and finish groups reporting to them. *Reports/escalations from local mortality monitoring groups.

FEEDER GROUPS

PATIENT SAFETY STEERING GROUP Chair: J Pearse/J Heywood
- Significant Incident Scrutiny Group
- Tissue Viability Steering Group
- Falls Group
- Acuity Group
- Thrombosis/VTE Committee
- Medical Devices Group
- Safety Thermometer
- Medication Safety Group
- CAUTI Group
- Blood Treck Panel

PATIENT EXPERIENCE STEERING GROUP Chair: J Cox/J Williams
- Essence of Care
- Patient Information & Involvement
- Patient Environment Delivery Group
- Friends & Family
- Nutrition & Hydration Strategy
- End of Life Care

CLINICAL EFFECTIVENESS/OUTCOMES STEERING GROUP Chair: Simon Corbett
- Resuscitation Committee
- Blood Transfusion Committee
- New Procedures Advisory Group (NPAG)
- Drugs Committee

SAFEGUARDING VULNERABLE ADULTS STEERING GROUP Chair: Gail Byrne
- Learning Disability Operational Group
- Dementia Operational Group
- Mental Health Operational Group
- Safeguarding Vulnerable Adults Operational Group

SUB GROUPS

RADIATION PROTECTION COMMITTEE
EDUCATION STRATEGY GROUP
SAFEGUARDING CHILDREN STEERING GROUP
CORPORATE HEALTH & SAFETY COMMITTEE
DIVISIONAL GOVERNANCE GROUPS
INFECTION PREVENTION COMMITTEE
REGULATORY ASSURANCE - REPORTING
POLICY RATIFICATION AND MONITORING GROUP (PRAM)

Updated May 2014
Quality Governance Assurance and Escalation Framework (this flowchart supports our embedded systems of assurance and escalation)

Quality & Performance
Monthly:
- Scrutinise non financial performance, access targets, quality etc.
- Review performance plans prior to trust Board submission

Trust Executive Committee (TEC)
Quarterly Review:
- Board Assurance Framework /Corporate Risk Register review /Risk Management
- Patient Safety
- Patient Experience
- Clinical Outcomes/Effectiveness/Mortality
- Monitoring/Issues
- Regulatory Assurance
- Infection Prevention
- Quality Governance Issues/Escalations
- PIF Reports, Dashboards etc
- HR Reports (Whistleblowing)

Monthly Review:
- Performance Report
- Reports from Sub Committees
- Divisional Performance Review Reports

Trust Board
Quarterly Review:
- Board Assurance Framework (BAF)/Corporate Risk Register/Risk Management
- Patient improvement framework Reports, Dashboards and KPIs
- Patient Safety
- Regulatory Assurance
- Patient Experience
- Clinical Outcomes/Effectiveness/Mortality
- Infection Prevention
- HR Issues/Reports/Whistleblowing (monthly)
- Quality Governance/ Gov reviews
- Cost Improvement Plans / Impacts
- Reports from Board sub coms – AAC etc

Clinical Advisory Group
Monthly Review:
- Monitor clinical quality, outcomes and patient experience metrics
- Review national and local clinical reports and identify learning
- Address concerns about clinical care / patient experience
- Develop clinical culture and behaviour

Audit & Assurance Committee
Quality Scrutiny:
- Board Assurance Framework (BAF)/Corporate Risk Register/Risk Management/Regulatory Assurance/Compliance
- Any escalated Governance issues
- Patient Safety and Health & Safety
- Patient Experience
- Regulatory Assurance/CQC
- Clinical Outcomes/Effectiveness/Mortality etc
- Infection/Prevention
- Internal and External Audit
- Reports/Functions
- Finance/Fraud/Bribery

Executive Risk Register Scrutiny Group
Review/update BAF and the Corporate Risk Register
- Make recommendations to TEC on escalation of Divisional/Care Group risks to the Corporate Risk Register or move a corporate risk to appropriate Divisional/Dept Risk Register
- Agree emerging risks and top risks each quarter

Quality Governance Steering Group (QGSG)
Reports from sub groups and Divisions, including: Safeguarding, Infection prevention, Education etc (See committee chart for further detail)
- Policy Ratification
- Ensuring regulations (CQC), national policy and internal and external recommendations are actioned
- Aggregate analysis of data and information
- Sharing of learning from incidents, complaints and claims
- Staff Surveys

Local Management
- Risks and risk registers
- Divisional/Care Group Governance meetings and assurance
- Divisional performance reviews Dashboards and KPIs
- CQC/external review/report and evidence collation
- Management of audits, incidents, safety, claims and complaints
- Aggregate analysis of data and information
- Accreditation / Inspection
- Staff Issues
- Education and learning

Feedback to Divisions to inform Performance Reviews
Review risks with Divisions at risk review meetings

Council of Governors
Constituencies & Stakeholders
### Outcomes
- Every speciality to identify a clinical outcome measure
- Improving Hospital Standardised Mortality Rate
- Improving care for patients with diabetes

### Experience
- Improving care and safeguarding of vulnerable adults in hospital
- Improving patients mealtime experience, with particular focus on the older person
- To provide safe and timely discharge of patients from UHS

### Safety
- To continue to improve the reporting & learning from incidents.
- Achieve a further 20% reduction in avoidable high harm falls and pressure ulcers
- To improve the identification and care of the deteriorating patient

### Performance
- To deliver the 18 week referral time to treatment (RTT)
- 95% of patients will wait no longer than four hours in the emergency department
- To deliver all cancer waiting times for patients

### Sustainability Priorities
- Deliver year 2 of the dementia strategy
- Achieve the National Stroke Pathway Standards
- One care pathway to be identified by each division, undertake an in-depth review.
- Delivering same sex accommodation
- Improving End of life care
- Effective Safeguarding of children
- Delivery of the Equality Delivery System
- Infection prevention and control
- Theatre safety checklist
- Preventing Never Events
- Safety walk about programme
- Whistle blowing helpline
- Delivery of screening programmes
- Reducing readmissions
- Improving outpatient services
- Developing our 7 day service

### Commissioning for Quality and Innovation (CQUINS) - To be confirmed
- Dementia and delirium (National)
- Reducing patient follow ups
- Person centred planning
- Improving response rate and net promoter for Friends and Family Test, rolling out to outpatients, day case and staff FFT (National)
- Improving patient experience through listening & acting on patient feedback
- Promoting harm free care through the safety thermometer and focus on a reduction in pressure ulcers (National)
- Choose and book
- Reducing ward moves
- Managing delayed transfers of care particularly for patients with a learning disability

### Supporting Strategies
- NICE guidance and Quality standards
- Trust policies and guidance
- Dementia Strategy
- Clinical Effectiveness & Outcomes strategy
- Patient Experience strategy
- Patient & Public Involvement strategy
- Nursing 6 C’s (compassion, care, competence, commitment, courage, communication)
- End of life Care Strategy
- Patient safety strategy
- Health and safety strategy
- Values & Culture
- Risk Management Strategy
- Infection Prevention Strategy
- Education Strategy
- Staff Experience strategy
- Monitor Compliance framework
- NHS operating plan
- Internal performance monitoring framework

### Trust 20:20 Vision & Values
- NHS Constitution
- Trust response to Francis report ‘Hard Truths’

**NB:** Key performance indicators have been developed to measure the priorities outlined above and will form part of the Trust reporting mechanisms.
Strategy Implementation

Corporate Responsibility and Accountability

The Trust Board

The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and has a statutory duty of quality, as part of its role, to ensure high standards of quality governance.

The Chief Executive has overall accountability for Quality Governance, delegating the executive responsibility to the Director of Nursing and Medical Director who in turn are responsible for reporting to the Trust Board on the quality governance agenda and ensuring that any supporting strategy documents are implemented and evaluated effectively. Other aspects of governance such as Financial, Information and Research form part of the relevant Executive Directors portfolios.

The Audit & Assurance Committee (A&AC)

Chaired and attended by Non Executive Directors, the A&AC provides an independent and objective view of internal control in accordance with clearly defined terms of reference. This group reviews and scrutinises the robustness of the Board Assurance Framework and the quality governance agenda across the Trust. The Non Executive Directors have an active role in providing assurance to the Trust Board on the management of risk and quality governance across the organisation.

Quality and Performance Committee

- The committee scrutinises the non-financial performance of the Trust
- Additional scrutiny may be focussed on elective or emergency access targets or other quality issues
- The committee is non-decision making and will act as a co-ordination group providing the opportunity for discussions about performance issues prior to action by the Trust Board.
- The committee is accountable and reports a summary of actions and recommendations to every Trust Board meeting.

Trust Executive Committee (TEC)

This committee is chaired by the Chief Executive (CEO) and consists of, Executive Directors, Divisional Clinical Directors, Divisional Directors of Operations, Divisional Heads of Nursing and Professions, the Head of the School of Medicine, Director of Education, Director of Human Resources and the Company Secretary and Head of Corporate Affairs, Director of IM&T and Director of Performance. TEC advises the CEO on key issues which affect the viability, safety and quality of services within the Trust by:

- Rigorous review of the high-level risk registers, Board Assurance Framework and quarterly governance reports (Safety, Experience, Outcomes/Effectiveness and Regulatory Assurance) on a quarterly basis.
- Ensuring there are clear and robust accountability arrangements at all levels of the Trust for financial probity and quality governance.
- Ensuring that intelligent information is available to support decision-making and effective operation of the Trust at all levels.
- Ensuring that organisational learning takes place.

The Quality Governance Steering Group (QGSG)

QGSG reports to TEC. It is the main quality committee for the Trust and its main remit is:-
To provide a clear vision for quality governance within the Trust to assist in working towards clinical excellence as identified in the Trust’s 20/20 vision.

To set clear governance performance standards and hold the Clinical Divisions, and where relevant other Trust wide groups and departments, to account for the delivery of the governance agenda.

To escalate any areas of concern to the Audit and Assurance Committee and/or Trust Executive Committee as appropriate.

To provide a level of scrutiny regarding governance, including compliance with regulatory requirements set by the Care Quality Commission and Monitor.

**Clinical Advisory Group**

The Clinical Advisory Group (CAG) provides opportunity for senior clinical leaders to meet and collectively review the patient quality in the Trust and agree ways on how it can further improve. In addition to ensure the clinical culture underpins safe care, evidence-based best practice outcomes and excellent patient experience. In addition to this Its main remit is:-

- To monitor clinical quality, outcomes and patient experience metrics.
- To review the Trust values, behaviours and clinical culture and advise if they are fit for purpose and recommend any modifications.
- To review national and local clinical reports and identify any learning for clinical teams and the organisation.
- To provide clinical advice to TEC and escalate any concerns about clinical care/patient experience

**Central Governance and Risk Team**

Whilst the main delivery of governance occurs within each of the Clinical Divisions and corporate departments the central Governance Team has a crucial role in:

a) Providing direction and impetus for action, interpreting and acting on national guidance.

b) Facilitating change within divisions, providing the divisions with the tools, skills and methodologies.

c) Ensuring consistency of approach and linkages between divisions and corporate departments.

Other corporate teams relevant to this strategy comprise of the following:

- The Patient Safety team is responsible for providing advice to the Divisions on patient safety issues; providing intelligent information on incidents, near misses and investigation outcomes; leading investigations relating to serious untoward incidents; and overseeing the implementation of patient safety strategies and work-streams. The team work closely with the Health & Safety team.

- The Patient Support Services team is responsible for the effective management of complaints and concerns, liaising with the Safety and Claims teams and the Divisions and providing intelligent information on patient experiences to aid organisational learning.

- The Clinical Effectiveness team - act as a central resource, performing corporate activities and audits and supporting the Divisional activities required to deliver the Clinical Effectiveness Strategy and Clinical Audit plan.

**Divisional Responsibility and Accountability**

**The Senior Divisional Management team**

The Divisional Management teams are accountable for the delivery of the Quality Governance agenda within their Divisions. It is the responsibility of Divisional Management teams to ensure that the governance values are embedded in their Divisions and this means:

- Awareness
  - All staff should know that robust risk management and quality improvement are key priorities for the Trust and understand how they can contribute to this agenda.
– All staff should be aware of what CQC compliance is and the purpose of the CQC standards
– All staff should be aware of the key Trust policies and processes and should comply with them.

- Compliance – each division should use the CQC standards to plan a programme of governance work to ensure compliance and year on year improvements in the quality of patient care are achieved (and build this into their business plan).

- Assurance - each divisional management team should be ‘assured’ (i.e. by evidence collation, walkabouts, surveys, audits etc) of, and able to demonstrate, compliance with the standards and other relevant accreditation requirements.

- Sharing and learning – divisions should share areas of good practice and learning across the Trust, both when things go well and when things could be improved.

- Leadership and drive for results – each division needs to support the Trust goal of being a centre of excellence and choice by continually striving to improve and by ensuring the Trust can set itself apart by its high quality of care.

**Divisional committee arrangements**

Each division is required to have a divisional governance structure with regular meetings to discuss and oversee all governance issues within the Division. To ensure accountability, the Divisions are required to submit a summary of their meetings to the QGSG on a monthly basis. Care groups may also have their own governance groups which report into the Divisional Governance Boards.

Divisions are required to ensure there is sufficient clinical representation within the Divisions and Care Groups Governance groups.

**Governance roles within the divisions**

Each division is required to have a Divisional Governance Manager who is responsible for the coordination of the governance agenda within the Division.

**Escalation and assurance processes**

The Trust has in place comprehensive policies and procedures which support the escalation and assurance processes of the organisation. All policies and procedures are easily accessible to staff through the Staffnet system. These lay out how to escalate information, for example, how staff can and should raise concerns through procedures such as incident reporting, whistleblowing, safeguarding, risk assessment and management or governance structures.

**Key Performance Indicators**

Compliance with this strategy if monitored through ensuring systems and processes are in place to provide reports, audit trails, scrutiny and assurance of good governance practices to the Trust Board and its sub-committees and internal and external auditors and regulators.

Where gaps in assurance are identified action plans are implemented and monitored. Any remaining residual risks are added to, and monitored through, the Trust’s risk registers.

Each of the supporting strategies outlined in the following sections have identified objectives and targets which are monitored through the relevant committees, performance indicators, dashboards and reporting structures.
Patient Safety Strategy

National data estimates that as many as 1 in 10 healthcare patients could be the victim of an unintentional but avoidable error. The Trust is committed to transforming its safety culture for lasting improvement, aiming to be an organisation where quality and safety is everyone’s top priority.

The Strategy has eight work streams:

- Reducing falls
- Reducing avoidable pressure ulcers
- Reducing medication errors
- Reducing healthcare associated infection
- Recognising and managing the deteriorating patient
- Venous thromboprophylaxis
- Improving learning from incidents

Each of these workstreams is overseen by a delivery group which reports to the Patient Safety Steering Group (PSSG) and ultimately Trust Board. Key performance indicators against each workstream are monitored by PSSG ensuring that progress can be measured and improvements made.

The ‘safe care in your hands’ campaign supports the safety strategy by:

- Improving incident reporting supported by the continued rollout of electronic incident reporting
- Providing a mechanism for staff to raise concerns via the Raising Concerns helpline and email facility
- Performing safety walkabouts under pinned by the safety conversation training program
- Temperature testing through a culture survey (Safety Barometer)

The Safety Thermometer is a measurement tool to support patient safety improvement. It enables frontline teams to monitor their performance in delivering harm free care. The Safety Thermometer records the presence or absence of 4 harms

- Pressure ulcers
- Falls
- Catheter Associated Urinary Tract infections (CAUTI)
- Venous Thromboembolisms (VTE)

An in depth patient safety report is submitted to Trust Board on a quarterly basis. In addition to workstream progress the report includes information and learning from safety walkabouts, safety thermometer and incident reporting.

The workstreams are evaluated on an annual basis in conjunction with the Patient Improvement Framework (PIF). Safety development for 2014/15 is as follows:-

- The delivery of the safety strategy and the patient safety PIF priorities for 2014/15
- A campaign to improve the quality of incident reporting in the Trust with a focus on correct impact validation and an increase in the number of near miss and no harm reports.
- Implementing a systematic approach to safety walkabouts, supported by safety conversation training
- Utilising social mobilisation methodologies to continually improve patient safety culture
- A plan to review all deaths using an Interim approach to the National Medical Examiner role.
- Providing assurance by demonstrating that lessons have been learned from incidents, claims and inquests at both an individual and organisational level.
- Ensuring we are candid and open with patients and families when things go wrong
- Improve education, training and development for investigating, learning from and managing incidents
- Review of incident reporting and management of incidents policy to ensure that this reflects local and national guidance aimed to improve reporting, management and learning from incidents.
Patient Experience Strategy

The following diagram represents the core themes and work streams of the strategy:

Our complete approach to improving patient experience:
The delivery of the patient experience strategy is the responsibility of the Trust’s Patient Experience Strategy Group, which meets six weekly to monitor patient experience and improvement targets set annually under each of the key themes and to develop and approve policies and guidelines relating to the key delivery areas of the strategy.

Annually, the Trust sets key patient experience targets through the Patient Improvement Framework and will be further developing its engagement plans in the next update of the Patient Experience and Engagement Strategy.

The Trust reports progress on patient experience and engagement every quarter to the Trust Board, via the Trust Executive Committee, the Quality Governance Steering Group and the Patient Experience Steering Group. A patient experience dashboard is established which represents all key performance indicators for patient experience, including CQUINS, national targets and locally set targets, which have been identified for improvement from patient surveys and consultation with service users.

Patient and Public Involvement

In 2011, the Trust developed a Patient and Public Involvement (PPI) strategy, which sets out how the Trust engages and involves the public, patients and its members in the planning, provision and evaluation of all aspects of its services. The strategy describes the things the Trust already does and sets out its plans to achieve high quality patient and public involvement over the next 3 years. The strategy includes the Trust’s PPI pledges, model, five overarching goals for PPI and its implementation plans for the first year of the strategy. Oversight of the strategy is the responsibility of the patient experience steering group. The Trust’s pledges and model for PPI is represented as follows. This year a program of experience based design will be undertaken to ensure that patients and users are involved in service delivery and design.

UHS PPI Pledges

<table>
<thead>
<tr>
<th>Pledge 1</th>
<th>We will make patient and public involvement a priority in all of our services, providing information that is clear, jargon free and accessible to all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pledge 2</td>
<td>We will involve people in a way that is open, honest and meaningful, being clear about what decisions they can and cannot influence</td>
</tr>
<tr>
<td>Pledge 3</td>
<td>We will consult on and involve people in the planning and redesign of services and provide feedback on the outcomes of consultations</td>
</tr>
<tr>
<td>Pledge 4</td>
<td>We will use a wide variety of ways to actively seek patient and public feedback on our services, listen to what people are saying and act on this</td>
</tr>
<tr>
<td>Pledge 5</td>
<td>We will tell people what we have done to improve services in relation to feedback and public opinion</td>
</tr>
</tbody>
</table>
Council of Governors and membership

UHS has a Council of Governors which has a key role in taking the hospital forward and ensuring it is meeting the needs of its communities. Its role is to:

- Advise the board of directors of the views of the membership community;
- Comment on the development of strategic plans for the hospital; and
- Act in a Trustee role making sure the hospital meets its obligations.

The Council is responsible for regularly feeding back information about the Trust, its vision and performance to the constituencies and stakeholder organisations. One of the Trust's key goals is to establish and deliver a valued based customer focused organisation and to put patients' needs first. At the heart of this goal is a strategy for developing a high quality patient experience so patients choose to be treated at the Trust. The Patient Experience Group (a sub group of the Council of Governors) provides a mechanism for ensuring that the Council is able to provide the Trust with independent and objective recommendations and support for enhancing the patient experience.

The Council consists of 23 members who gather the views of the hospital's staff, patients, carers and stakeholders and give them a voice at the highest level of the organisation. There are also thirteen seats on the Council are for public members who wish to have more of a say in UHS’s services and play a part in linking with the membership community. The Trust also has a substantial membership who takes an active role in the decisions made at the Trust. The role of the membership and Council will continue to be developed further in 2014/15.

Patient Feedback and Surveys

Patient feedback on experience and quality are actively sought through:

- annual surveys and service specific surveys of patients who have recently used Trust services
- the use of frequent feedback surveys (real time feedback)
- feedback forms, the Trust's and NHS Choice’s websites and email contact
- reference groups and listening events
- patient panels in care groups
- feedback from local community and representative groups e.g. Healthwatch

Stakeholder involvement in Trust committees

UHS actively encourages appropriate external representation on its key quality committees both from representatives of patients and other providers/commissioners/stakeholders.

UHS involvement in external partnerships and committees

UHS staff also attend a variety of external engagements to provide information and feedback about the quality of services provided by the Trust. These include the Southampton and Hampshire Healthwatch, the Health Overview & Scrutiny Committee and other providers, commissioners and community/patient groups.
Clinical Effectiveness and Outcomes Strategy

The NHS Outcomes Framework includes three domains that cover the Clinical Effectiveness (CE) component of high quality care: preventing people from dying prematurely, enhancing quality of life for those with long term conditions and helping people to recover from episodes of ill health or following injury. Our CE vision is to ensure we achieve outcomes that equal or exceed the best in the NHS.

CE can be summarised as ensuring practice is based on evidence so that we do ‘the right things the right way to achieve the right outcomes’ for our patients.

In the Trust a number of activities are drawn together under the CE heading. The figure below shows how these activities relate to other aspects of the Trust’s commitment to high quality care.

The Board approved a renewed CE and outcomes strategy in December 2011, its key themes are:

1. **Ensuring our practice is based on the best available evidence.**
   This includes: contributing to National confidential Enquiries; putting NICE guidance into practice; applying NICE quality standards; having local guidelines that are fit for purpose.

2. **Using our clinical audit programme as a force for improvement across all services.**
   This means focusing on the priorities, implementing change and ensuring we follow through on findings.

3. **Using outcome measures to inform us, our patients, the public and commissioners on our performance.**
   This includes mortality measures; patient reported outcome measures (PROMs) and a wide range of other local and nationally monitoring outcomes.

4. **Innovation to improve outcomes in a safe and sustainable way.**
   This includes the safe introduction of new procedures, as well as support for adoption and spread. In addition there is supporting activity – ensuring we undertake education and training, sharing and celebrating good practice, reporting on performance, policy development, monitoring, and evidence collation.
Quality Governance Summary

This strategy is an overarching strategy for the achievement of Quality Governance which draws together the relevant supporting strategies covering Patient Safety, Patient Experience, Patient & Public Involvement and Patient Outcomes. It has been developed to ensure that Quality Governance is an integral part of Trust business and is at the heart of our clinical practice and service provision. The effectiveness and objectives of the strategy will be reviewed at least annually by the Quality Governance Steering Group.

Our Trust strategies integral to Quality Governance include:

- Patient and Public Involvement Strategy
- Patient Safety Strategy
- People Strategy
- Patient Experience Strategy
- Car Parking Strategy
- Coaching and Mentoring Strategy
- 2020 Estate Strategy
- Infection Prevention Strategy
- Information Management & Technology Strategy
- Clinical Effectiveness/Outcomes Strategy
- Education and Learning Strategy