Southampton University Hospitals NHS Trust

Quality Governance Strategy

2011-2013
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Key Messages from this Strategy

The Core Elements of the Strategy:

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**QUALITY GOVERNANCE IMPLEMENTATION**

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

Context of the Strategy

This Quality Governance strategy is an overarching strategy which outlines the plan for the continued development of Quality Governance at Southampton University Hospitals NHS Trust. 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
- Clinical Effectiveness/Outcomes Strategy
- Regulation and Assurance (including Risk Management)

SUHT’s 2020 Vision is to be a world-class centre of clinical and academic achievement, where staff work 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 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*
What is Quality Governance?

Quality governance is 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

The key concepts of this Quality Governance Strategy

- Drawing the quality governance streams of work together to help the organisation function more effectively
- Embedding 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 is subject to rigorous challenge

What do we want to achieve?

As a Trust we are aiming to achieve:
- Continuous improvement of patient care and excellent clinical outcomes for patients.
- A patient centred and patient led approach to care that includes treating patients courteously, involving them in decisions about their care (no decision about me without me – DH 2010) and keeping them informed.
- The delivery of services developed in response to feedback from patients, the public and other key stakeholders such as service commissioners and Local Involvement Networks/Healthwatch.
- A reduction of the risk from clinical errors and adverse events, as well as a commitment to learn from mistakes and share the learning across the trust.
- An environment which is safe for both patients and staff and supports their needs and well-being.
- Assurance that the Trust is well managed and compliant with regulatory requirements.
- Engagement of all our staff in services which are clinically led and owned.

The Trust's Strategic Objectives

In line with the above the Trust has set three strategic objectives for 2010/11, these are:
- Trusted on Quality
- Delivering for taxpayers
- Excellence in healthcare

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
## Quality Governance Objectives

- **Clear direction and realistic goals**
  
  Continue to set a clear direction for the implementation of Governance through realistic goals that take into account the organisational context, but still strive for continual improvement.

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

- **Meeting regulatory requirements**
  
  Deliver continual compliance with the Care Quality Commission's (CQC) new registration system and ‘Essential Standards of Quality and Safety’.

  Maintain and improve on the Trust’s assessments in relation to the NHS Litigation Authority Risk Management Standards and other external accreditations.

- **Governance and Risk Management framework**
  
  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 quality improvement as well as risk minimisation.

- **Accountability**
  
  Continue to ensure that explicit and robust accountability arrangements are in place and effective at all levels of the Trust.

  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.

- **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.

  Ensure that intelligent information and regular reports are available to support decision-making and effective operation of the Trust at all levels.

### Governance annual work programme 2010-2013

- Evidence collation and continued scrutiny of compliance with CQC Regulations and the Essential Standards of Quality and Safety
- Building on the Trust’s successful assessment of NHSLA Maternity Clinical Risk Management Standards at level 2, work towards level 3 achievement
- Achievement of NHSLA Acute Risk Management Standards level 3
- Improvement of Policies management and archiving, to support achievement of the above
- Continued development of the processes, scrutiny and monitoring systems for the accreditations and inspections taking place throughout the organisation
- Reviewing and adapting systems and practices to meet the needs of regulatory and legislative changes and developments
- Using internal and external learning to ensure continuous quality improvement
Risk Management Strategy

A key component of Quality Governance 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:

<table>
<thead>
<tr>
<th>Risk Management Objectives</th>
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<tbody>
<tr>
<td>➢ Adopt an integrated approach to the management of risk and integrate risk into the overall Quality Governance arrangements.</td>
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<tr>
<td>➢ Support the achievement of the Trust's objectives as set out in the Annual Plan, the Integrated Business Plan and the Trust's Vision for the future.</td>
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<tr>
<td>➢ Comply with national standards and with the NHSLA's Risk Management Standards.</td>
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<td>➢ Have clearly defined roles and responsibilities for the management of risk.</td>
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<td>➢ Maintain a safe environment for patients, employees and visitors.</td>
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<td>➢ Ensure that risks are continuously identified, assessed, reported and minimised.</td>
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<td>➢ Develop activity to support the Trust's Board Assurance Framework through ongoing review of local and corporate risk registers.</td>
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<tr>
<td>➢ To use risk assessments and intelligent risk information, gathered from a variety of sources, to inform the overall business planning/investment process in the Trust, as well as other components of governance i.e. clinical effectiveness, audit and education and training.</td>
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<tr>
<td>➢ Ensure the provision of a robust system for reporting and analysis of incidents with timely learning for all staff.</td>
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<td>➢ Foster an open and honest culture that allows organisation wide learning.</td>
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<td>➢ Establish clear and effective communication that enables information sharing.</td>
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<td>➢ Ensure that any concerns over sub-optimal decision-making or practice are identified quickly and dealt with in a proactive and supportive way.</td>
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<tr>
<td>➢ Provide intelligent information and feedback at various levels of the organisation in order to assist decision making.</td>
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<tr>
<td>➢ Improve quality of care and the patient experience.</td>
</tr>
</tbody>
</table>

How quality governance is applied in practice

In March 2007 SUHT Trust Board 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 9.

The PIF focuses on patient safety, patient experience and patient clinical outcomes and regulatory 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 strategies:

- Patient Safety Strategy
- Patient Experience Strategy
- Clinical Outcomes and Effectiveness Strategy

These strategies are outlined on pages 12 to 14.

To ensure our strategies 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 below shows the Trust’s Governance Committee structure and the Flowchart on page 8 demonstrates how our assurance reporting processes flow from Ward to Board and Board to Ward.
Quality Governance Assurance Reporting Framework

**Trust Board**
- Board Assurance Framework (BAF) and Corporate Risk Register top risks reviewed Quarterly.
- Patient improvement framework reports, dashboards and KPIs
- Receive Quarterly reports on:
  - Patient Safety
  - Regulatory Assurance
  - Patient Experience
  - Clinical Outcomes/Effectiveness
  - Infection Prevention

**Trust Executive Committee**
- Quarterly review of BAF and Corporate Risk Register.
- Agree recommendations from ERRSG.
- Quarterly reports on:
  - Patient Safety
  - Regulatory Assurance
  - Patient Experience
  - Clinical Outcomes/Effectiveness
  - Report to Board
  - Infection Prevention
  - QGSG update reports/escalations

**Audit & Assurance Committee**
- Scrutiny of Corporate Risk Register/BAF. Rolling programme of review of Divisional/Care Group Risk Registers.
- Scrutiny of CQC compliance
- Scrutiny/review of any escalated governance concerns
- Receive Quarterly reports on:
  - Patient Safety
  - Regulatory Assurance
  - Patient Experience
  - Clinical Outcomes/Effectiveness
  - Infection Prevention

**Executive Risk Register Scrutiny Group**
- Review Board Assurance Framework and the Corporate Risk Register.
- Make recommendations to TEC of escalation of Divisional/care Group risks to the Corporate Risk Register or move a corporate risk to appropriate Divisional/Dept Risk Register.

**Quality Governance Steering Group**
- Reports from sub groups and Divisions, including: Safeguarding, Infection prevention, Education, Major Incident, etc (See committee chart).
- Policy approval
- Ensuring national policy and internal and external recommendations are actioned.
- Aggregate analysis of data and information

**Local Management**
- Management of risks, risk assessments and risk registers.
- Divisional/Care Group Governance meetings and assurance.
- Divisional performance reviews.
- Dashboards and KPIs.
- CQC/NHSLA/external review/report evidence collation.
- Management of audits, incidents, safety and complaints.
- Aggregate analysis of data and information

**Feedback to Divisions to inform Performance Reviews**

**Review risks with Divisions at risk review meetings**
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 Assurance Framework and the quality governance agenda across the Trust. Non Executive Directors have an active role in providing assurances to the Trust Board on the management of risk and quality governance across the organisation.

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 and the Director of Corporate Affairs. TEC advises the CEO on key issues which affect the 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 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. 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 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 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; and compliance against NHSLA Risk Management Standards.

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 Complaints Department is responsible for the effective management of complaints, liaising with PALS, Claims and the Divisions and providing intelligent information on patient experiences to aid organisational learning.
- The Clinical Effectiveness team under the direction of the Director of Clinical Effectiveness act as a central resource, performing corporate activities and supporting 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 quality improvement is a key priority for the Trust and understand how they can contribute to the agenda.
  - All staff should be aware of what CQC compliance is and the purpose of the Essential Standards of Quality and Safety.
  - All staff should be aware of the key Trust policies and processes and should comply with them.

- Compliance – Each Division should use the standards to plan a programme of Governance work to ensure improvement year on year (and build this into their business plan) and ensure the CQC registration and compliance requirements applicable to them are met.

- 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 be sharing 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 ensure the Trust can set itself apart by the quality of its care. Each Division should be looking to make year on year improvements in the quality of patient care.

Divisional committee arrangements

Each Division is required to have a Divisional Governance Board which meets regularly 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 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.
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.

Integrated 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 Integrated Safety has eight work streams:

- Reducing falls
- Reducing medication errors
- Reducing avoidable pressure ulcers
- Reducing healthcare associated infection
- The implementation of the WHO surgical checklist
- The deteriorating patient
- Improving nutritional assessment
- Venous thromboprophylaxis

Each of these work streams has an annual improvement plan, which is overseen by a delivery group. Key performance indicators against each work stream ensure that progress can be measured the improvement aim of moving the dot.

The Trust's Patient Safety Steering Group and ultimately Trust Board oversee the delivery of the work streams. An in depth patient safety report is submitted to Trust Board on a quarterly basis. In addition to work stream progress the report includes information and learning from trigger tool audits, safety walkabouts and incident reporting.

The work streams are evaluated on an annual basis in conjunction with the Patient Improvement Framework.

Safety development for 2011-12 is as follows:-

- The development of a safety thermometer to measure the indicators of patient safety risk being faced by the Trust.
- Agreement of future work streams
- Using mass mobilisation theory to influence and embed the drive for improvement
- Ensuring the ward accreditation scheme demonstrates Ward to Board assurance on monitoring patient safety and where there is non compliance appropriate action is taken.
- A review of the Safety Strategy
Patient Experience Strategy

The Trust’s Patient Experience Strategy was developed in 2008 and is currently under review prior to a strategy refresh in early 2011. There are 10 themes incorporated in the patient experience strategy as detailed in the diagram below.

The delivery of the patient experience strategy is the responsibility of the Trust’s Patient Experience Strategy Group, which meets 6 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. A number of sub committees, which include patient representation, report to the Patient Experience Strategy group including:

- Nutrition Steering Group
- Essence of Care Group
- Trust Wide Patient Information Group
- Customer Care Group
- End of Life Care Group

Annually, the Trust sets 5 key patient Experience targets through the Patient Improvement Framework.

The Trust reports on Patient Experience 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.
Patient and Public Engagement

Members’ Council and membership

SUHT has a Members’ Council which has a key role in taking the hospital forward and ensuring it is meeting the needs of its communities. Its role is to:
Advising 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 Members’ Council is responsible for regularly feeding back information about the Trust, its vision and performance to the constituencies/classes 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 Members’ Council) 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 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 SUHT’s services and play a part in linking with the membership community. The Trust also have a substantial membership who take an active role in the decisions made at the trust. The role of the membership and Council will continue to be developed in the Trust’s move towards Foundation Trust status.

Patient Feedback and Surveys

Patient views on quality are actively sought through:
- annual surveys and service specific surveys of patient’s 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
- a variety of other initiatives looking at patient outcomes.

Stakeholder involvement in Trust committees

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

SUHT involvement in external partnerships and committees

SUHT 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 SLINks, the Health Overview & Scrutiny Committee and other providers, commissioners and community/patient groups.
Clinical Outcomes and Effectiveness Strategy

Clinical effectiveness has been included as one of the three domains of high quality care alongside safety and patient experience. Clinical effectiveness is about 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 clinical effectiveness heading. The figure below shows how these activities relate to other aspects of the Trust’s commitment to high quality care.

The clinical effectiveness strategy includes the following key activities:

1. Knowledge management – ensuring staff have access to and know how to use the evidence they require.
2. NICE - ensuring that NICE guidance informs and influences practice, and that we know how we are performing
3. NCE - ensuring that we participate in National Confidential Enquiries and that their findings inform and influence practice, and that we know how we are performing
4. Clinical audit – ensuring that our programme is effective, informed by our priorities, addresses the requirements of the contract and delivers improvement where required
5. New procedures – ensuring we have a system that promotes the safe introduction of new procedures and devices
6. Outcomes – ensuring appropriate outcome measures are developed for all clinical areas and that these help monitor and improve the quality of care
7. Patient reported outcome measures – ensuring that the Trust participates in the national PROMs programme and uses locally developed PROMs where appropriate
8. Mortality rates – ensure that the Trust monitors the HSMR and takes any necessary action to reduce the mortality rate.
9. Linking with safety – ensuring that Morbidity and Mortality meetings are effective and undertaken across all clinical areas and that the wider programme for patient safety links effectively with other aspects of clinical effectiveness.
10. Supporting activity – ensuring that education and training, sharing and celebrating good practice, reporting on performance, policy development and monitoring, NHSLA compliance and evidence collation are undertaken.
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 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.

Other Trust strategies integral to Quality Governance include:
- Information Management & Technology
- Estates
- Infection prevention
- Data Quality Governance Steering Group
- Transport
- Education & Learning

2020 Vision – SUHT’s long term strategy