Monitor

Quality governance:
How does a board know that its organisation is working effectively to improve patient care?

Guidance for boards of NHS provider organisations

April 2013

Monitor's role

Monitor's main duty is to protect and promote the interests of patients. We do this by promoting the provision of health care services which is effective, efficient and economic, and which maintains or improves the quality of services.

We assess NHS trusts for NHS foundation trust status and ensure that NHS foundation trusts are well-led (from both a quality and finance perspective) and financially robust so that they are able to deliver excellent care and value for money. We license NHS foundation trusts (other eligible providers of NHS services will be licensed from April 2014) and:

- enable integrated care;
- safeguard choice and prevent anti-competitive behaviour which is against the interests of patients;
- support commissioners to protect essential health care services for patients if a provider gets into financial difficulties; and
- set prices for NHS-funded care in partnership with NHS England.

We work closely with our partners to help ensure that the providers of NHS-funded services, and the commissioners of those services, are able to make sure that the best possible care is delivered for patients.

Find out here[1] how we work with the Care Quality Commission, NHS England, NHS Trust Development Authority and the National Institute for Health and Care Excellence (NICE) for the benefit of patients.

Further information on our role can be found on our website: www.monitor.gov.uk

The purpose of this guidance

Monitor's *Quality Governance Framework* was introduced in 2010 in response to the lessons learned from the failings at Mid Staffordshire NHS Foundation Trust and tighter public finances. The latter increases the risk that financial savings might affect quality of care. Assessing themselves against this Framework allows trusts to satisfy themselves, patients and Monitor that effective arrangements are in place to continuously monitor and improve the quality of health care provided and that areas highlighted through the process as requiring further work are effectively addressed. However, Monitor is aware that not all NHS foundation trusts realise the amount of work required to achieve this. This made clear to us the need for supporting guidance for boards of directors on this issue.

This guidance is therefore written primarily for members of boards of NHS organisations to enable them to perform their role in improving health services for patients. It is designed for use across all types of NHS providers, including existing and aspirant NHS foundation trusts in the acute, specialist, ambulance, community and mental health sectors. However, it may also be useful to other staff in NHS bodies, such as senior management, operational, clinical and nursing staff and those working on internal, external and clinical audits.

Why this guidance matters

The Francis Report into the failings at Mid Staffordshire NHS Foundation Trust strongly reinforces that quality should be at the heart of a patient-centred NHS. Quality of care provided is a key responsibility of the boards of NHS foundation trusts. Monitor considers that maintaining and improving quality is an important indicator of the effectiveness of governance at a trust. We use the three dimensions of quality identified by Lord Darzi: clinical effectiveness, patient safety

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[1] http://www.monitor.gov.uk/about-monitor/how-we-do-it/working-together-patients

and patient experience, which are now enshrined in the Health and Social Care Act 2012.

As the NHS changes, quality remains as important as ever and boards must continue to focus on quality improvement. In accordance with their provider licence, boards are required to ensure that they meet a number of obligations concerning the governance of the quality of care that the trust provides. While the regulatory regime is changing, these new arrangements are intended to mirror those of the *Quality Governance Framework*. This guidance lays out one way of gaining assurance that such requirements have been met effectively and comprehensively.

Main themes

Setting standards for caring for patients is of little use unless those standards are routinely upheld. Boards must scrutinise data and be confident that the data is meaningful and trustworthy. They need assurance that the processes for the governance of quality are embedded throughout the organisation. This guidance emphasises the need for fundamental standards and measures of compliance in relation to better standards of care and an enhanced role for all clinical staff in organisational leadership and culture. Moreover, the board should understand the organisation and that what they're being told is true, accurate, fair and backed up with sufficient evidence. This requires good data quality systems in place to deliver that data and a culture that supports ethics and candour.

This guidance also covers some practical steps that boards can undertake, such as board walk-arounds with actions to follow up, regular staff surveys and having procedures in place that enable staff to feel confident that they can raise concerns and that these will be taken seriously. It concludes with a list of questions boards may want to ask themselves to assess how well they are doing.

Contents

1. Introduction

Why this guidance is important

1. The focus of all NHS organisations is improving patient care.

> **Lord Darzi established a single definition of quality in his 2008 review *High Quality Care for All*.[I] This definition which is now enshrined in law through the Health and Social Care Act 2012, comprises three dimensions of quality, all of which are required for a high-quality service:**
>
> *   **clinical effectiveness;**
>
> *   **patient safety; and**
>
> *   **patient experience.**

2. The quality of care provided impacts directly on health outcomes, the way patients experience care, the safety of care and the cost of care. It will also impact on the reputation of the organisation and the wider NHS.

Monitor's *Quality Governance Framework*

3. A robust governance framework for quality is essential throughout every NHS organisation. It provides assurance to the chief executive, the chairman, the board of directors, the council of governors, senior managers and clinicians that the essential standards of quality and safety are being delivered by the organisation. It also provides assurance that the processes for the governance of quality are embedded throughout the organisation.

4. Given this requirement, Monitor developed the *Quality Governance Framework*. This has been embedded into our assessment process for aspirant NHS foundation trusts from August 2010 and included in the *Compliance Framework* for existing NHS foundation trusts from April 2011.

5. The *Quality Governance Framework* raises the profile of quality for the boards of organisations. 'Quality governance' is the combination of structures and processes at and below board level to deliver trust-wide quality services. If implemented effectively, assessment against the Framework should provide boards with assurance over the effective and sustainable management of quality throughout their organisation. It should also enable them to approve assurances to Monitor on quality governance with confidence. The *Quality Governance Framework* has four domains and ten questions **(figure 1)**.

[I] *High Quality Care for All: NHS Next Stage Review Final Report*, Department of Health, June 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_0 85825

Figure 1: Four domains of Monitor's *Quality Governance Framework*[I]

Strategy	Capabilities and culture	Processes and structures	Measurement
1A Does quality drive the trust's strategy? 1B Is the board sufficiently aware of potential risks to quality?	2A Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 2B Does the board promote a quality-focused culture throughout the trust?	3A Are there clear roles and accountabilities in relation to quality governance? 3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? 3C Does the board actively engage patients, staff and other key stakeholders on quality?	4A Is appropriate quality information being analysed and challenged? 4B Is the board assured of the robustness of the quality information? 4C Is quality information used effectively?

About this guidance

6. This guidance has been developed to support the *Quality Governance Framework* and its samples of good practice and does not seek to replace it. It aims to:
    - help boards understand what is required of a trust's internal assurance mechanisms for assuring the organisation-wide processes for governing quality with a view to improving decision-making; and
    - support boards in discharging their responsibilities to improve care for patients.

    In particular, this guidance should support NHS foundation trusts in making the Corporate Governance Statement required under Monitor's new licence conditions (see table 1 on page 26).[II] It can also support aspirant NHS foundation trusts in making their board statement on quality governance as part of Monitor's assessment process.

7. The publication of this guidance is particularly relevant and timely in the context of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry [III] which was published in February 2013. Its recommendations highlight the importance of quality governance and quality assurance arrangements within the NHS. The report emphasises the need for fundamental standards and measures of compliance in relation to better standards of care and the enhanced visibility of clinical staff in organisational leadership and culture.

[I] *Quality Governance Framework*, Monitor, July 2010. http://www.monitor.gov.uk/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/quality-governance-fr

[II] *The new NHS provider licence*, Monitor, February 2013. http://www.monitor.gov.uk/sites/default/files/publications/ToPublishLicenceDoc14February.pdf

[III] *Mid Staffordshire NHS Foundation Trust Public Inquiry,* Chaired by Robert Francis QC, 6 February 2013. http://www.midstaffspublicinquiry.com/report

8. A main tenet of the guidance is quality, and the ownership of good quality governance, begins with the staff of an organisation. The level and extent of their authority, decision-making and behaviours will vary but it is essential that all staff understand how they can contribute.

9. It is designed for use across all types of NHS provider, including: NHS foundation trusts and aspirant NHS foundation trusts across the acute, specialist, ambulance, community and mental health sectors. Although aimed at boards in the first instance, it is applicable across a range of functions within a trust, including: senior management; internal, external and clinical audit functions; and operational, clinical and nursing services. It will also support inspection and regulatory functions.

10. Good quality governance should be based on the following concepts:

Concept	Description	What this means in practice
Engage and Cascade	*Engaging with stakeholders to set quality priorities and standards and communicating these across the whole organisation.*	The board, through engagement with others both within and outside the organisation, sets the priorities and expectations for the organisation. Specifically, a board clarifies the strategic direction, quality priorities and values for the organisation and defines how performance against these key areas will be measured and monitored. These priorities and expectations need to be clearly communicated and cascaded to all levels of the organisation to provide a strong sense of purpose, clarify boundaries and enhance accountability.
Assure and Escalate	*Ensuring that high quality care is being delivered and risks to quality are being effectively managed.*	The board uses processes and systems of assurance and escalation to gain insight and intelligence internally and externally on the quality of its services (in particular where services are underperforming or even harming patients). These processes and systems will also hold management and clinicians to account for their performance.

11. This guidance aims to improve assurance and escalation through providing:

- the key questions a board should be asking itself;
- the principles that support effective assurance and escalation; and
- examples of how different trusts are approaching this challenge.

Methodology

12. The guidance has been developed through consultation with trusts **(Appendix B)** in order to:
    (1) understand internal assurance mechanisms currently in operation;
    (2) develop principles of good practice, including specific examples that are referred to throughout; and
    (3) identify potential areas for improvement.

An 'Editorial Panel' was also formed, comprising representatives from the NHS, academia and regulators, to provide insight and expertise and to review drafts.

Themes

13. Through consultation with trusts and a review of assessments of quality governance arrangements, we have identified four main themes **(figure 2)**. These themes highlight challenges that many trusts face in implementing effective quality governance arrangements and have been used to underpin the structure of the guidance, rather than mirroring the structure of the *Quality Governance Framework* directly. In any case, each section of the guidance highlights the relevant questions from the Framework. **Appendix A** provides detailed questions to help trusts to map their quality governance assurance activity with the domains and questions detailed in the *Quality Governance Framework*.

14. The themes (set out below) are underpinned by a range of management activities and assurance processes that will be familiar across the NHS:

- **engagement on quality**: Does the board lead on quality, engaging effectively with others to set goals for improvement and performance monitoring?
- **gaining insight and foresight into quality**: Are governance systems, processes and behaviours effective enough to help the board understand what stakeholders expect and believe the trust can deliver, and how this information will help them improve the quality of care provided?
- **accountability for quality:** Is everyone in the organisation clear about the standards expected of them in delivering high quality and safe care and the need to provide assurance in relation to care quality and the escalation of any quality concerns?
- **managing risks to quality**: Is there sufficient, relevant and reliable management information and performance metrics to identify and resolve risks?

Figure 2: Themes underpinning the guidance
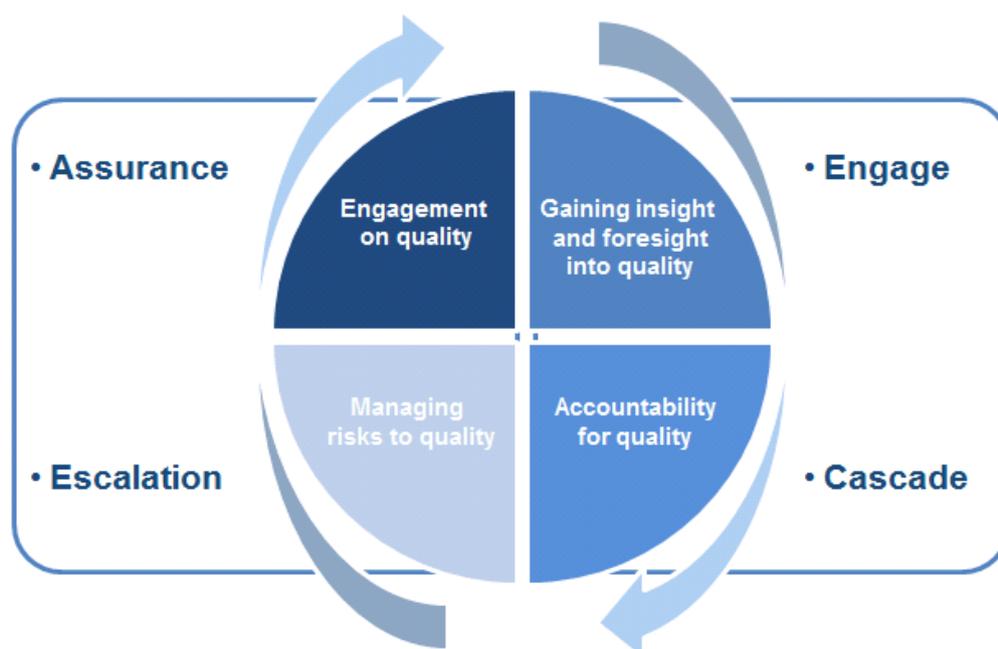
2. Engagement on quality

Introduction

15.   A highly engaged board working in true partnership with the senior leadership team and wider staff, and where applicable the council of governors, is a critical factor in the successful delivery of quality improvement. This section sets out how NHS organisations can improve the way they engage others on quality.

16.   Boards should consider the following when considering how they promote quality:
   - leadership; and
   - communication.

Leadership

> **Board Assurance**
>
> - *Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve?*
>
> - *Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership? What is your evidence for this?*

17.   Good boards will set system-level expectations, accountability for high performance and ensure that all staff understand their role in the effective and high-quality provision of care.

Board leadership

Quality Governance Framework Good Practice	
1A Does quality drive the trust's strategy? Including:	**2A Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?** Including:
• ambitious trust-wide quality goals; • local and national priorities; • high impact; • SMART objectives; • link to divisions and services; • action plans; and • effective communication.	• rigorous challenge; • full non-executive director engagement; • capability and understanding; • confidence; • evidence impact; • evaluation; and • training.

18.   By focusing on quality, and bringing the knowledge and skills to challenge the organisation, boards foster a quality culture. Without support from high-level leadership, initiatives to improve quality will either fail to take off or will not be sustained in the longer-term.

19.   **Skills and behaviours:** Boards must ensure that they have the right mix of skills, capabilities and capacity to oversee and test good quality governance. If the board and wider organisation recognise and respect the distinctive skills and expertise of individual executive and non-executive board members, then they will have a positive impact. Many boards are putting in place formal, regular and independent evaluations

of their board effectiveness to ensure that it is dynamic and capable of meaningful challenge.

20. **Challenge:** The board must ensure that it achieves a balance between trust, constructive debate and effective challenge. A lack of challenge, with submissions to the board receiving insufficient scrutiny or debate can lead to quality performance issues. Too much challenge and executive members may become defensive and self-protective, seeking to manage or circumvent the discussion, which will undermine the board's effectiveness.

Culture

> *Quality Governance Framework* **Good Practice**
> **2B Does the board promote a quality-focused culture throughout the trust?**
> Including:
> - active quality leadership;
> - proactive improvement and learning;
> - committed resources;
> - board engagement;
> - encouragement of staff participation, training, delivery and reporting on harm/errors; and
> - internal communication on quality.

21. Organisational culture guides the behaviour of individuals and simultaneously is shaped by those behaviours. In quality governance, the influence of organisational culture is critical to the development of attitudes around patient safety and quality improvement.

22. **Sub-cultures:** One of the biggest challenges for executive and non-executive members of boards and senior managers is how to ensure that smaller cultures, or sub-cultures within a trust, do not affect the integrity of the whole culture or system. Sub-cultures that are allowed to develop negatively can lead to issues ranging from poor satisfaction to the failure to detect serious deficiencies in quality.

23. **Cultural leadership:** An organisation that puts patients first will be one that demonstrates a culture of openness and learning. It is also one where staff feel able to raise concerns about quality of care at an early stage and trust that these will be effectively addressed.

24. Many trusts have adopted a range of road shows, events and appointed 'champions' that support strategic initiatives designed to change the culture. However, these require investment of resource: both in terms of dedicating knowledgeable staff to the promotion of the change, in a supportive role, but also in dedicating board and clinical leaders' time. Many board members and clinicians understand and demonstrate the effectiveness of an unannounced quality-focused visit to ensure that a quality culture is cascading down the organisation. However, more objective tools are available, such as the Manchester Patient Safety Framework, designed to assess the organisation's safety culture.

25. More geographically widespread organisations such as ambulance, mental health and community trusts will face greater challenges in influencing the culture of their organisation. This may also be the case where a number of organisations, each with their own cultures, come together within one trust.

Clinical and non-clinical leadership

26. **Clinical leaders:** Clinician input into safety and quality improvement is critical for predicting the 'bedside impact' of changes, and for creating new ideas within and across clinical and professional boundaries. Because any profession is most likely to listen to advocates who understand their values and challenges, a clinical leader is very important in gaining the support of other clinicians. It is also essential to help sustain any change, as clinicians are often part of the organisation over a much longer period than senior managers.

27. **Participation at board-level:** One way of engaging clinical leaders on quality is to encourage their active engagement with the board or the Quality Committee. For example, some Quality Committees have introduced a rolling bi-monthly programme of direct scrutiny and challenge of clinical units. Clinical staff, including clinical directors and ward matrons, report on quality performance concerns and improvements to the non-executive directors. And in turn, clinical leaders should then cascade relevant issues down to their clinical units.

28. **Non-clinical leaders:** Non-clinical leaders are also vital to achieving effective quality governance and their role must not be underestimated by boards when seeking assurance on the quality of services. Non-clinical leaders may include senior service managers or heads of estates, facilities, information and data quality, patient engagement, waiting-list management and health and safety.

29. A number of trusts have taken a variety of proactive approaches to improve the leadership skills and activities of clinicians and managers to complement the assurance received by the board. Some of these include:

    • encouraging the active contribution by clinical leaders and staff towards the setting of the organisation's vision and corporate values;
    • involvement and participation in the structured walk-arounds by board members, including the setting of programmes based on known quality issues;
    • joint ownership of feedback to staff, communicated via clinical leaders to avoid a 'them and us' culture;
    • encouraging clinical units to 'own' deep dives in particular clinical areas, through peer challenge;
    • using the Medical Engagement Scale to assess medical engagement in management and leadership in NHS organisations;
    • the integration of a range of patient feedback into key performance indicators at clinical unit level; and
    • presentations to the board on initiatives that have had a measurable impact on quality and safety.

30. **Ownership:** The regular challenge of any unexpected trends or outliers in the main 'dashboard' indicators and quality and risk profiles should be fed to the board by the management, including by clinical leaders. This should involve clinical units undertaking regular review cycles of more detailed indicators in specific clinical areas and escalating these to the board.

31. **Accountability:** Successful organisations are good at bringing all staff groups into the fold and promoting effective leadership at all levels in all disciplines and job roles. Clinical and non-clinical leaders and staff should be just as accountable for the delivery of the quality agenda. Strong triumvirate leadership arrangements between nurses, doctors and managers are often seen at high-performing trusts.

Communication

Board Assurance

- *Does the board understand the effectiveness of the methods used by the trust for communicating to and involving staff, patients and stakeholders in the quality agenda?*

32. In order for communication and engagement to be effective it must: proactively involve all relevant internal and external stakeholders; be sustained and systematic; and be meaningful. Communication is the critical factor in enabling trusts to realise their vision and values, to define and achieve their strategic quality goals and objectives, to monitor outcomes and to understand where good care is optimised and also where it can be improved.

Quality Governance Framework Good Practice
3C Does the board actively engage patients, staff and other key stakeholders on quality?
Including:
- transparent and accessible quality outcomes;
- patient and staff feedback and views sought and reviewed;
- a range of approaches taken;
- quality performance communicated and discussed with stakeholders, e.g. commissioners; and
- governor involvement.

From board to ward – communicating effectively with staff

33. Effective communication from the board to front-line staff is essential for quality improvement. The most powerful tool that an organisation has in achieving its goals and objectives are its staff. However, staff can be often unconnected to or unaware of the activities and the plans of the board and how these relate to their working lives.

34. **Involvement in the development of strategic plans:** The initial development of strategies, such as quality improvement, should actively consider how staff will be engaged. In response to a concern that staff engagement was a particular challenge, one trust set up a staff engagement design group, with external and independent support, to lead the improvement process and their Staff Engagement Strategy. The benefits were felt beyond staff engagement, as this work also supported a wide range of board-level initiatives, including development of estates reconfiguration, the annual plan and quality improvement.

35. **Clinicians:** Clinical involvement should include the ongoing review of clinical developments and national guidance in order to determine organisational priorities. The Advancing Quality Programme is an example of how clinicians can help set up quality standards that define and measure good clinical practice.

36. **Accessible information:** The data and information that a board receives should be communicated to the relevant staff as early as possible. It should include a specific reference to the quality issues that the board is considering as well as standing items such as policy updates, audit results, quality outcomes (including complaints, incidents and claims), local, organisation and national updates on quality performance and performance benchmarks. One trust has communicated its quality goals by developing a 'quality improvement tree' where the branches are made up of strategic themes and the leaves are the refined goals.

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37. **Ensure that staff know how to raise issues within the organisation:** Linking to the leadership of the quality agenda, all staff should understand the reporting hierarchy and the ultimate responsibility for quality issues in the organisation. Some staff spoken to as part of the *Quality Governance Framework* assessment process struggle to articulate, beyond their immediate line-manager, who the individuals are that have accountability for quality within their organisation. A number of trusts have expanded whistle-blowing policies to include how the trust will deal with all concerns raised at work and formalise the processes for when and how issues will and will not be dealt with in a confidential manner.

38. **Regularly seek and review the results of staff feedback:** All trusts participate in a national staff survey. However, some have difficulty in showing how this serves the board's knowledge and understanding of staff in the trust and also how they can use these surveys to influence greater staff satisfaction and improved patient experience. Trusts that proactively carry out regular 'local' staff surveys, or 'temperature checks' are much closer to understanding the ongoing effects of decisions made by the board on staff morale. They will also find it easier to make connections between staff satisfaction and the patient experience. Some trusts have included specific areas that must be addressed in conversations between boards and staff when they meet, for example: early warning indicators of the impact of cost improvement programmes; staff suggestions to improve service quality; priorities for the next year's Quality Account; and their top three safety concerns.

Patients and carers

39. Understanding quality means understanding what patients experience, yet it is sometimes difficult to extract meaning from the ever-increasing range of patient and service user feedback mechanisms. While many trusts do actively seek out this feedback, there is still often a sense of a lack of connection between patient feedback and obvious improvements. Yet patients, carers and families do have a significant role to play, not only in designing improvements, but in monitoring whether they have had the desired impact.

40. **Put in place and test methods to engage patients in quality improvement:** Many trusts are seeking to engage better with patients and the number of tools to assist with this is increasing. For many trusts this is a key development area. Trusts should evaluate the effectiveness of these tools and learn from the results. Some trusts have developed a map of parts, or the whole, of the patient pathway or journey. 'Process mapping' is a useful tool for patients to understand how the different steps in a patient journey fit together. This not only creates an expectation but can also allow the patients and their carers to understand where their feedback has had the most benefit.

41. **Encourage participation:** Merely putting in a process is not enough. Processes should be user-friendly as there are many reasons why capturing the patient experience will not be an easy task. While many patients may be easy to engage with, trusts also need to involve harder-to-reach groups such as children, older people or those with mental health conditions through family members and carers who may be better placed to provide feedback. Technology-based approaches can be efficient but may not appeal or always be accessible.

42. **Patient stories:** Using real patient stories at the board can focus the board on quality of care. Choosing the right story strengthens the impact. Some trusts link the story to management information and patient pathways in order to show specific actions and impact. Stories can be both positive and/or negative, but it is important that the board is sensitive to the difficulties associated with patients attending boards in person. An

alternative option is for the patient stories to be read out to the board instead. It is good practice for patients and service users to be supported by their nurses or consultants before, during and after their appearance at the board.

43. **Responding to engagement:** Patients whose views are actively sought or who contribute their views, concerns or complaints must be kept informed of how this information is being treated, what they can expect and ultimately the outcome as a result of this engagement. Too much feedback can be solicited with little or no reference to the purpose or the envisaged impact. Staff, in particular, should be informed of feedback from patients and carers and be encouraged to take ownership by leading the trust's response. Many trusts actively use forums where patients can give feedback about specific services, for example maternity, stroke and heart attack support groups, expert patient programmes, learning disability groups and carers' groups.

44. **Quality Accounts:** A number of trusts are now taking a much more joined-up approach to using their Quality Accounts. The best approach involves a direct link between the Quality Accounts and a trust's Quality Strategy, the former being seen as both the internal and external communication method for the latter. Many trusts have introduced a monthly quality report to the board that mirrors the content of the Quality Account. This, in turn, improves the assurance that the board receives at the end of the year when the Quality Account is signed off.

Public, governors' and members' involvement

45. It is tempting for trusts to focus on the patient as the service representative. However, it is equally important to acknowledge the wider role of trust members and the public and their elected representatives, the governors, as the potential consumer. Consultation with trust members and the public will help trusts ensure that their work is prioritised in a way that is relevant to both current and potential service users.

46. **Using public consultation to shape strategy:** Failure to involve the public is likely to increase unplanned demand and lead to services being planned on the basis of perceived rather than actual need. Some trusts that have recently attained NHS foundation trust status have deliberately built on the consultation exercise around the trust's application. These consultations involve an extensive number of meetings and presentations and, rather than treat them as a one-off exercise, they allow the process to develop, with ongoing regular meetings for example with the public and members.

47. **Methods for public engagement:** The role of the NHS foundation trusts' governors and members is critical. Their roles continue to develop but are acknowledged as representing the trust in the community and holding the non-executive directors to account. Trusts should actively consider how governors can successfully receive assurance that this is achieved. For example, some trusts are using patient 'champion' governors who are fully involved in the internal quality assurance and quality improvement processes, such as clinical audit, complaints handling, staff training, and patient safety. Governors are required to represent the interests of their NHS foundation trust members and the public and should have a particular interest in providing constructive challenge to non-executive directors on the performance of the board of directors in this area.

Commissioners and partners

48. Commissioners should make sure that their decisions are informed by knowledge of patient experience. Consequently trusts, commissioners and partners, such as other health care providers, GPs and local authorities, should develop shared patient experience goals as part of developing good working relationships. This means performance and incentive systems need to be aligned across organisations so that they recognise and reward innovative measurement and improvement.

49. **Work in partnership:** Boards must understand the challenge and scope for improving patient experience in individual organisations and across whole health economies. Consultation needs to happen early in the development process or partners' inputs will not have an impact. Some trusts have been notable in their proactive consultation on their Integrated Business Plans and, in a smaller number of cases, quality or clinical strategies by involving partners, such as GPs, Clinical Commissioning Groups (CCGs), Health Overview and Scrutiny Committees and local MPs.

50. **Integrate commissioners' experience as a crucial dimension of quality:** Commissioners have a unique role in that they are, in reality, the 'customer' as opposed to the 'consumer'. GPs, in particular, will have significant face-to-face contact with the patient and will also have knowledge of local hospitals and senior doctors. CCGs will therefore play an important role in identifying and driving continuous quality improvement. In addition to information from regulators, CCGs will have their own intelligence based on contract monitoring and patient and public engagement. Trusts therefore need to ensure that they have considered the views of commissioners in setting and monitoring quality goals.

51. The best performing partnerships between trust and commissioner will be using Commissioning for Quality and Innovation (CQUINs) as a positive measure to recognise and reward quality improvement and aligning these to mutual quality goals.

Summary

The trust board can gain assurance through:

- *the development of a culture that encourages participation and is supported by resources to promote change. The board will need to put in place systematic processes that allow it to know that this is being effectively achieved by, for example: using a programme of quality-focused ward walks to allow two-way interaction with patients and staff; commissioning patient and (medical and clinical) staff surveys on understanding values and their impact, utilising peer reviews to test and challenge implementation to support the board's understanding that this is developing effectively;*

- *systematic and timely processes for engaging staff, commissioners, partners and patients in the creation, development and communication of quality indicators and goals. This should be visible to the board through specific communication and engagement plans and projects. Progress measured against wider engagement plans can be assessed directly through internal and clinical audit programmes or be triangulated via board-level engagement with stakeholders. Governors of NHS foundation trusts should provide constructive challenge to non-executive directors on the performance of the board of directors in this area;*

- *communicating data and information that the board receives to the relevant staff. Seek out and review staff feedback, underpinned by regular board to staff engagement, the use of regular staff and patient surveys and to test the effectiveness of communication and trends over time. The trust can also use internal audit functions to test the extent of staff awareness and the use of performance information used by the board;*

- *using public consultation to shape strategy and process design with outcomes from engagement and consultation fed back to those affected and the impact of this to be measured through board engagement;*

- *using patients to design improvements, and monitor impact, including incorporating involvement and feedback into project management systems for service pathway redesign; and*

- *reflecting NHS commissioners', local authorities', and GPs' views in setting and monitoring quality goals and quality improvement strategies.*

3. Gaining insight and foresight into quality

Introduction

52. This section explores various ways that trusts can gain insight and foresight into the quality of care provided to patients and carers.
    - **Insight**: to govern effectively the trust must have knowledge and understanding about what its stakeholders (patients, the public, commissioners, government and regulators) expect from the trust; and what these stakeholders have experienced of the trust's delivery against their expectations.
    - **Foresight**: the effective use of this information will help boards respond effectively to future challenges.

53. This section considers various key aspects of how the trust uses information to gain insight and foresight, namely:

    - measurement, reporting and monitoring;
    - data quality; and
    - benchmarking.

Measurement, reporting and monitoring

> **Board Assurance**
>
> - *How are you assured that the board is receiving the right type and level of information on quality of care?*
>
> - *Have you compared the information you receive with other NHS trusts of similar type and complexity?*
>
> - *Are the 'hard' facts and data consistent with what you are hearing and observing around your trust?*

> *Quality Governance Framework* Good Practice
> **4A Is appropriate quality information being analysed and challenged?**
> Monthly board 'dashboard' includes:
> - national and regulatory priorities;
> - range of quality metrics;
> - early warning indicators, adverse events and harm measures;
> - Monitor's risk ratings;
> - qualitative narrative; and
> - links to strategy.
> Boards must ensure these are:
> - comprehensive and relevant;
> - granular; and
> - regularly reviewed to maximise effectiveness.

54. Provider assurance and decision-making processes rely on effective measurement and reporting of quality information. Alongside national, regional and local metrics, a trust board should debate and agree a set of quality metrics (in conjunction with its financial metrics). These must be relevant to the board in the context within which it and its partners are operating. The information and metrics should be relevant, timely and accessible.

55. **National standards:** The board should clarify its priorities and expectations; this should include the adoption of nationally approved standards and targets. These should align to, for example, the Care Quality Commission's (CQC) Essential Standards of Quality and Care; Monitor's governance risk ratings; the Department of Health's *NHS Outcomes Framework*; and the principles and values defined in the NHS Constitution.

56. **A strategic integrated performance dashboard:** This would allow comparison and triangulation across quality, performance, workforce, productivity and finance metrics. An analysis of trusts demonstrating good practice indicates that there is a generic range of useful information that can be triangulated to give a comprehensive picture of performance of a trust, for example: Hospital Episode Statistics (HES) data; patient experience surveys; complaints, claims and patient safety incident reporting; Patient Reported Outcome Measures (PROMS); national and local clinical audit findings; and post-investigation complaints and staff surveys. Trusts have also found it helpful to include an overview summary matrix of their quality performance by division or service so that they are better able to see any adverse performance within the overall aggregate level.

57. **Detailed performance scorecards:** These are aligned to main strategic goals and provide monthly historical representation of data and benchmark positions. Trusts are increasingly using standardised scorecards at the board, which are then expanded and used by divisions and service lines to measure trust-wide and local goals. Ward-based dashboards should be aggregated to allow better benchmarking between services. Some trust leaders have electronic access to real-time dashboards that allow them to see on any one day how the trust is performing against its priorities.

58. **Ward- and service-level dashboards:** These allow staff to better understand both trust and team goals and enable bottom-up explanation for any variances and any necessary clinically-led mitigation taken as a result. Analysis and commentary, including trends analysis, allow for effective performance projection and risk analysis. This should be a regular process that limits the time that staff are away from their front-line care duties.

59. **Quantitative versus qualitative:** Boards should be sensitive to the risk of quantitative performance measurement existing in isolation. 'Hard' data that can be measured must be supported by 'soft' performance measurement that involves more personal and subjective interaction and measurement throughout the organisation. There is a range of soft information-gathering approaches that a trust can draw upon, for example:

- While certain executives are likely to be frequently present on wards and sites, for many, such as non-executive directors, opportunities for informal board visits need to be sought out within a formalised and safe framework. One trust has buddied each of its non-executives with an executive member and linked them to every ward. The wards have clarity as to who is taking an interest in their performance and the opportunity this presents to have a route to the board.
- Alternative arrangements will be needed for those locations within a trust that are geographically removed, such as community and mental health services and ambulance stations. Additionally, certain staff groups will need to be considered because of their hours of working, for example, night staff and lone working staff.
- Patient and staff stories: boards should try to focus on stories that relate to a particular quality issue, for example, delayed transfers of care or staff shortages in a particular area or department. Stories, both positive and negative, can provide valuable lessons on quality.

- Core groups within a trust that may be overlooked due to the nature of their employment, that is, their roles and tenure, are junior doctors and temporary staff. They therefore may not be as involved in communicating with the board and the senior managers on performance issues. Consequently, some trusts have identified a specific non-executive to be a link between junior doctors and the board.

Data quality

> **Board Assurance**
>
> - *How are you assured that the data you use to inform decisions is robust and valid?*

Quality Governance Framework Good Practice
4B Is the board assured of the robustness of the quality information?
Quality data is supported by effective:
- clearly documented data assurance controls;
- clinical governance;
- clinical audit programme based on risk;
- electronic systems where possible;
- audit trails and ownership;
- audit action plans and follow-up; and
- accurate clinical coding.

60. Effective performance management relies heavily on trusts' ability to have good quality data that underpins the assessment of performance.

61. **Six dimensions:** Trust boards should regularly review their arrangements for supporting how they prepare and report performance indicators. This review should cover the data collection, checking and reporting processes in place for producing the information and testing the systems and controls in relation to the six dimensions of data quality.

Figure 3: The six dimensions of data quality[I]

Accuracy	Is data recorded correctly and is it in line with the methodology for calculation?
Validity	Has the data been produced in compliance with relevant requirements?
Reliability	Has data been collected using a stable process in a consistent manner over a period of time?
Timeliness	Is data captured as close to the associated event as possible and available for use within a reasonable time period?
Relevance	Does all data used to generate the indicator meet eligibility requirements as defined by guidance?
Completeness	Is all relevant information, as specified in the methodology, included in the calculation?

[I] *2012/13 Detailed Guidance for External Assurance on Quality Reports*, Monitor, March 2013
http://www.monitor.gov.uk/sites/default/files/publications/ToPublishDetailedGuidanceExternalAssuranceQualityReports22March2013.pdf

62. **Assurance sources:** Trust boards require assurance on the quality and reliability of their data. Where there is assurance, there is often limited understanding as to how much reliance can be placed on that assurance. Trusts noted for their good practice use their internal audit and clinical audit assurance services to set up a comprehensive and prioritised review of key aspects of data quality. This will provide a degree of assurance regarding data quality process and controls when supported by an effective data quality steering group. Data quality audit programmes should reflect the trust's Key Performance Indicators (KPIs) and be based on a risk assessment of those indicators on which the trust places the greatest reliance.

63. **Relationship to quality:** A board must assure itself that the measures of quality reported to the board actually reflect the quality of care as delivered to the patient. Before a board assures itself that indicators are measured reliably it must be assured as to their fundamental validity.

64. **Data quality programmes:** In many instances trust board members may believe that they are assured regarding data quality on the basis of reporting against the Information Governance Toolkit[I] or on the basis of external audit's limited assurance opinions on the Quality Accounts.[II] Boards must understand the limited nature and coverage of such reports and try to establish data quality assurance programmes that have comprehensive coverage. Triangulation of different sources of data and information is an effective way for boards to validate the quality of the data provided. A number of trusts have put in place programmes of data quality review that incorporate:

   - following good practice in clinical record-keeping;
   - audit and coding accuracy tests;
   - record-keeping and case-notes of quality audits;
   - analysis of outliers; and
   - data quality indicators showing, for example, RAG (Red, Amber and Green) assessment of KPIs as a standard for data accuracy.

65. **Data quality strategy:** The purpose of a data quality assurance programme is to give the board the assurance that it needs to have confidence across all the elements of information on which it bases its decision making. This includes identifying those areas where they may not be fully confident and additional work therefore must be done. Many trusts are putting in place data quality strategies. A data quality strategy is different to a policy in that it drives quality improvement, with clear SMART (Specific, Measurable, Achievable, Realistic, Timely) objectives, supported by a comprehensive programme of data quality review. This should be used as a tool to allow the board to review the progress and the degree of assurance that it can obtain relating to the information it receives. The trust board should incorporate clear data quality metrics as these are developed and actively engage services in the development of the strategy.

66. When developing a data quality strategy, trusts should consider moving from a paper-based to an electronic record system. The subsequent electronic reporting of, for example, clinical and diagnostic data and matching of different types of information as part of a clinical software system, such as the use of handheld devices, can be an effective way of getting better and quicker information on quality and patient safety.

[I] *Information Governance Toolkit*, Department of Health. https://www.igt.connectingforhealth.nhs.uk/

[II] *Consultation on proposed changes to Quality Report requirements for 2012/13*, Monitor, December 2012. http://www.monitor.gov.uk/home/news-events-and-publications/consultations/consultations-monitor's-role-foundation-trust-regula-0

Benchmarking

Board Assurance

- *Could you name the best and worst performing services from a quality perspective within your trust and how these services compare with other trusts?*

Quality Governance Framework Good Practice
4C Is quality information used effectively?
Information in Quality Reports should be:
- clear and consistent;
- compared with target, historic performance and benchmarks;
- timely;
- 'on demand' where high priority;
- 'humanised' where possible; and
- able to demonstrate how information reviews result in actions that improve quality.

67.   **Improving performance:** Benchmarking, through comparisons with a peer group, aims to improve organisational and operational performance. The effective and continuous use of benchmarking should enhance performance by learning from the successful practices of others.

68.   **Learning:** Performance should be benchmarked against comparable organisations where possible. A number of trusts are beginning to utilise 'peer reviews', 'collaborative improvement' and Boards on Board Programmes as a means of identifying how they use good practice in another organisation to drive improvement in their own. The aim of peer review is to encourage the sharing of experience, knowledge and expertise.

69.   **Greatest need:** Benchmarking should reflect where there is the greatest need or potential for improvement. This might include the analysis of hospital speciality and individual consultant mortality data and mortality outliers relating to a range of specific conditions.

70.   **Internally-facing:** Boards should give as much weight to the benefits of internal benchmarking across its own services as well as to comparison with external organisations. There are many missed opportunities for internal benchmarking between services. Service level dashboards help trusts to achieve this, but these must be supported by a SMART analysis of comparative data. For example, 'complaints adjusted by number of patient episodes' enables comparative analysis between services.

71.   **Appropriate:** Care should be taken to benchmark with an appropriate group to avoid false assurance. External reports such as the Dr Foster Hospital Guide and the National Quality Dashboard can provide more objective comparison or, as a minimum, inform the board about the information the public can see about their organisation. In addition, external benchmarking clubs such as CHKS, regulators like the CQC or patient experience portals such as www.iwantgreatcare.org or The National Workforce Assurance Tool[i] will drill down into performance and provide information that can be used both internally and externally to benchmark performance.

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[i] *The National Workforce Assurance Tool*, Strategic Health Authorities and the Department of Health. https://northwest.ewin.nhs.uk/knowledge/resource/807/The-National-Workforce-Assurance-Tool

Summary

The trust board can gain assurance through:

- *the use of a strategic integrated performance dashboard that includes quality, performance, activity and finance targets aligned to strategic goals, which visibly cascades down to ward and service level dashboards;*

- *the use of 'soft' performance measurement, such as board visits and patient stories, which are supported by formal mechanisms for capturing, reporting and reacting to this information;*

- *a formalised strategic approach to data quality improvement aligned to quality governance. This should be supported by regular data quality metrics and a data quality assurance, process mapping and audit programme will allow the board to receive assurance that this is effective; and*

- *actively benchmarking performance with comparable organisations based on risk assessing areas of greatest need; internal benchmarking and 'peer reviews'; and a robust analysis of historical data.*

4. Accountability for quality

Introduction

72. Overall accountability for quality begins and ends with the board. However, a board cannot effectively discharge this role without the accountability for quality being clear throughout the organisation. Every board is responsible for holding management to account for meeting the expectations it has set and delivering its priorities. A board should seek and obtain assurance that:

    • roles and responsibilities throughout the levels of management are clearly defined;
    • quality is appropriately covered in board meetings and in relevant committees and sub-committees; and
    • there are relevant processes and structures in place to support the Corporate Governance Statement required by Monitor and other regulatory submissions.

73. All board members have a personal responsibility to assure themselves that the organisation is well-run, based on professional experience and personal judgement about the accuracy and completeness of what they have seen, heard and understood from submissions. In discharging their accountability for quality, trusts should consider how they will address:

    • assurance;
    • the Corporate Governance Statement required by Monitor and other regulatory submissions;
    • roles and responsibilities; and
    • the role of internal audit, clinical audit and internal governance.

Assurance

> **Board Assurance**
>
> • *What are the main sources of assurance upon which you rely?*
>
> • *Are you able to distinguish between assurance and reassurance?*

74. This guidance seeks to clarify confusion that can exist at board level and throughout organisations as to the distinction between:

    • **Assurance**: Being assured because the board has reviewed reliable sources of information and is satisfied with the course of action;
    • **Assumption**: Being satisfied that there is no evidence to the contrary; and
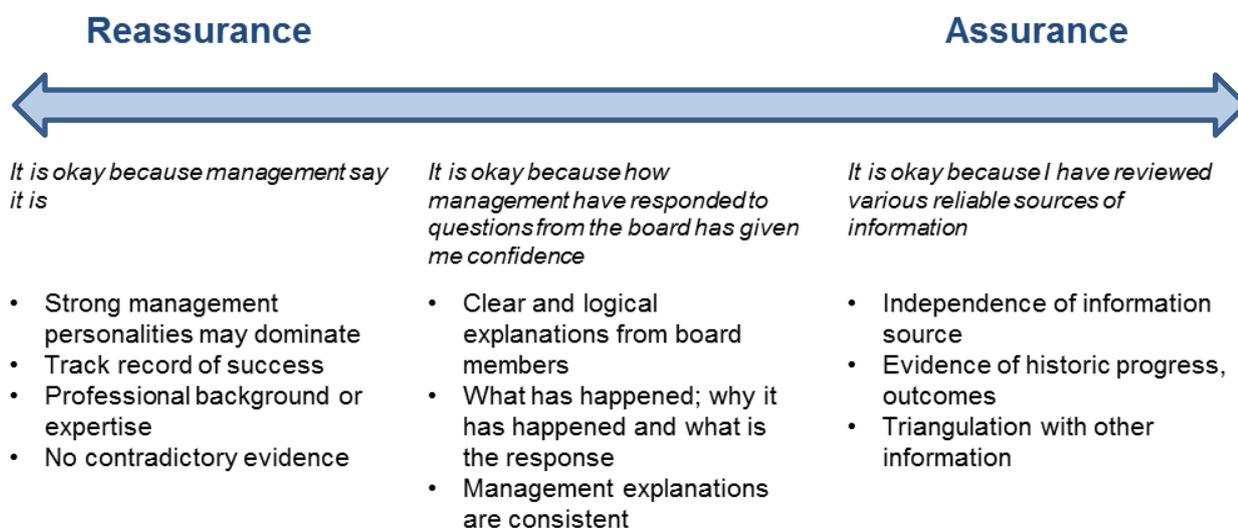   • **Reassurance**: Being told by the executive or staff that performance or actions are satisfactory.

> *Quality Governance Framework* **Good Practice**
> **3A Are there clear roles and accountabilities in relation to quality governance?**
> Including:
> • All board members' understanding of their ultimate accountability;
> • clear structures cascading responsibility;
> • quality is core part of board discussions; and
> • quality-focused sub-committee.

Figure 4: Types of board assurance

Reassurance   ## Assurance

It is okay because management say it is

It is okay because how management have responded to questions from the board has given me confidence

It is okay because I have reviewed various reliable sources of information

- Strong management personalities may dominate
- Track record of success
- Professional background or expertise
- No contradictory evidence

- Clear and logical explanations from board members
- What has happened; why it has happened and what is the response
- Management explanations are consistent

- Independence of information source
- Evidence of historic progress, outcomes
- Triangulation with other information

75. **Triangulation:** Board members are assured when they are either satisfied with the accuracy and completeness of what they are being told and/or they are confident that a set of actions will result in the outcomes intended. Board members consequently rely on the triangulation of various sources and types of information, a number of which are outlined below.

- There is evidence to support the accuracy and completeness of information;
- Management presents a clear understanding of root causes and consistency;
- There are detailed and credible assumptions underpinning action plans;
- Indicators of quality performance are valid;
- There is confidence in how board members work together and challenge the evidence;
- There is not a long-failed history of trying to sort out the issue or problem;
- The organisation has a track record of delivering something similar in the past;
- The issue can be resolved directly by the board;
- Independent advice has been sought from appropriately qualified people;
- The board has been free from bias and undue influence; and
- 'Peers' would be likely to reach a similar judgment on the basis of the same information.

Assuring the Monitor on quality governance

Board Assurance

- *Is there a clear trail of assurance underpinning the board statements and declarations?*

> **Quality Governance Framework Good Practice**
> **1B Is the board sufficiently aware of potential risks to quality?**
> Including:
> - assess and address current and future risks to quality;
> - up-to-date risk register, fed by divisions;
> - initiatives assessed for quality with clinical sign-off and monitoring;
> - clear ownership;
> - capturing staff concerns;
> - early warning indicators identified;
> - post-implementation; and
> - mitigating action.

76. The boards of both aspirant and existing NHS foundation trusts must assure Monitor that they have effective and sustainable quality governance arrangements in place. The requirements for trust boards are outlined below.

Aspirant NHS foundation trusts

77. Monitor has stipulated that all NHS foundation trusts should have suitable quality governance arrangements in place at the time of authorisation. The process for assessment includes providing a board certification that quality governance arrangements are satisfactory; and that the trust has a *Quality Governance Framework* score of less than 4.[i] Trusts will still need to prove that they have suitable quality governance arrangements in place since the terms of authorisation were replaced by the provider licence in April 2013.

78. Some trusts have found it useful to map their quality improvement strategy to the *Quality Governance Framework*. This has a clear benefit in assisting board members to understand how they are addressing the regulatory regime where they will obtain assurance.

NHS foundation trusts

79. Since 2011, NHS foundation trusts have been required to give consideration to the *Quality Governance Framework* as part of Monitor's regulatory regime. This included providing board statements to certify that the board is satisfied that their trust has, and will keep, in place effective arrangements for the purpose of monitoring and continually improving the quality of health care provided to patients. To support this statement, boards have been expected to formally assess themselves against the *Quality Governance Framework* in establishing their own quality processes.

80. In addition, NHS foundation trusts are also required to include details of their quality governance arrangements in their *Annual Governance Statement* and state within the *Annual Report* how the trust has considered the *Quality Governance Framework* as well as a summary of action plans to improve the governance of quality. This is then signed off by the trust's chief executive.

A changing regulatory regime

81. The provider licence has changed the regulatory regime. It reinforces the importance of quality. As the NHS changes, quality remains as important as ever and boards must focus on quality improvement. Reports from key board committees should be heard at

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[i] *Applying for NHS foundation trust status – A guide for applicants.* Monitor, April 2013.
http://www.monitor.gov.uk/sites/default/files/publications/ToPublishGuideForApplicantsApril2013.pdf

an early part in board meetings, for example after the chief executive's update, rather than left until the end. Trusts should also familiarise themselves with the National Quality Board's report: *Quality in the new health system: Maintaining and improving quality from April 2013.*[l]

82. From 2013/14, NHS foundation trusts have a licence setting out their requirements as NHS providers. As part of their licence, they have a licence condition representing Monitor's expectations regarding their governance. This condition includes obligations regarding the governance of the quality of care that the trust provides, including capability, leadership, planning, information, measurement and engagement in relation to quality of care. These arrangements are intended to mirror those of the *Quality Governance Framework* (see **table 1** below).

Table 1 - Obligations regarding the governance of the quality of care in the licence

> Under Monitor's new provider licence, paragraph 6 of licence condition FT4: NHS foundation trust governance arrangements requires that:
>
> a) there is sufficient capability at board level to provide effective organisational leadership on the quality of care provided;
> b) the board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
> c) accurate, comprehensive, timely and up to date information on quality of care is collected;
> d) the board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
> e) the licensee, including its board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
> f) there is clear accountability for quality of care throughout the licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the board where appropriate.

83. As part of their annual forward planning process, NHS foundation trust boards will make an annual Corporate Governance Statement to Monitor, reflecting:

-   compliance, in the coming year, with all the requirements of the governance condition (including the quality governance requirements); and
-   risks to that compliance and mitigating actions.

This statement replaces the 16 board statements in the current *Compliance Framework*. The Annual Governance Statement will continue as it is until such time as the Annual Governance Statement and Corporate Governance Statement may be combined.

84. The changing regime means that there is an ongoing need for trusts to have clearly understood structures of assurance supporting statements and declarations by the board. In particular, declarations in relation to the *Quality Governance Framework* and quality governance should be underpinned by transparent assurance mechanisms that can evidence baseline assessments against the framework and the assessment

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[l] *Quality in the new health system: Maintaining and improving quality from April 2013.* National Quality Board, August 2012. https://www.wp.dh.gov.uk/publications/files/2012/08/nqb-quality-draft.pdf

should be updated annually or on a rolling basis. Such an assessment would lend additional focus to assurances given by the provider trust to regulators and partners.

85.   Trusts should be wary of restricting their assurance approach to the minimum standards indicated by the *Quality Governance Framework*, the Annual Governance Statement and the Quality Accounts. The board should consider using the internal audit function to provide an overview of the assurances that have been obtained and how these address the regulatory and compliance regimes. This will enable boards to understand where potential gaps may exist and further action must be taken.

86.   All trusts should develop an overarching Assurance and Escalation Framework. This should be available to staff. This document should provide an aggregated summary of crucial policy and procedural documents and should describe, as a minimum, the board's requirements for seeking internal and external assurance.

87.   It should lay out how to escalate information. For example, this may include being clear about how staff can and should raise concerns about:
   - the impact of Cost Improvement Plans (CIPs) on the quality of care;
   - defined and understood processes for exception reporting of incidents to the board;
   - identification of data quality concerns and the application of a robust programme of data quality review; and
   - identification of early warning triggers in relation to workforce, finance and clinical services.

88.   NHS trusts and NHS foundation trusts should also include a report on the quality of care they provide within their annual report (Quality Report or Quality Account). The aim of this is to improve public accountability for the quality of care and include a statement on quality from the chief executive and set out the trust's priorities for improvement.

Roles and responsibilities

Board Assurance

- ***Do you understand how quality governance assurance processes operate across the organisation's committee structure?***

Quality Governance Framework Good Practice	
2A Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? Including: - rigorous challenge; - full non-executive director engagement; - capability and understanding; - confidence; - evidence impact; - evaluation; and - training.	**3A Are there clear roles and accountabilities in relation to quality governance?** Including: - all board members' understanding of their ultimate accountability; - clear structure cascading responsibility; - quality is core part of board discussions; and - quality-focused sub-committee.

89.   The effective board will need to rely on its supporting structures to enable it to carry out its role efficiently. However, problems can occur when roles and responsibilities are unclear. The board needs to ensure that both it and its committee structures can demonstrate that the quality governance agenda is being adequately covered while

minimising potential gaps and duplication. In addition, chairs' issues, and minutes of meetings, should be circulated to all relevant parties.

90. **Committees:** The board should ensure that its governance processes fully incorporate the committees and sub-committees, working groups, clinical leaders, clinical teams and support services from the board down through the organisation to those who work directly with patients. Many boards delegate responsibility for seeking assurance that there are effective arrangements in place for monitoring and continuously improving quality to a Quality Committee. This committee will usually have a clear responsibility for clinical governance and obtaining assurance that clinical risks are being managed and action taken to mitigate the risks. The Quality Committee generally has a range of sub-committees reporting to it, such as patient safety, patient experience and clinical audit.

91. **Escalation:** Sub-committees of the board and sub-committees within a trust are essential. However, there is a likelihood that the larger the number of committees the greater the challenge there will be in ensuring effective communication and escalation. Many tiers of supporting committees effectively put management layers between the board and the individual member of staff. In addition, a multitude of diverse committees covering one large area – such as patient experience, clinical effectiveness and patient safety within quality – can result in a lack of visibility of the agenda and communicate to others that responsibility for this area lies with some and not others. Boards should be conscious that delegation to committees and other groups may lessen the ability for the board to sufficiently assure itself in relation to quality governance.

92. **Audit Committee:** Our experience is that the number and profile of quality-focused committees is increasing. This can be matched by a decrease in visibility or understanding of quality assurance processes on the part of the audit committee, particularly where audit committees are too focused on finances. In such cases, the audit committee should focus on providing assurance to the board that the systems and process are functioning effectively so that the board is discharging its duty and those committees that are reviewing quality information in more detail are doing so effectively. Where boards rely on other structures (such as sub-committees) to provide assurances about clinical quality, there must be a clear and effective flow of information from them to the board.

Audit function

> **Board Assurance**
>
> - *Do you understand the role that your audit functions have in supporting board assurance on quality governance?*

Quality Governance Framework Good Practice
3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
Including:
- escalation processes understood, governed and documented;
- action plans supported by ownership, delivery and follow-ups;
- learning shared and implemented;
- impactful clinical and internal audit processes in relation to quality governance;
- 'whistleblower'/error reporting process; and
- effective performance management system.

Internal Audit Role

93. There are two key elements to the role of internal audit as defined by HM Treasury:[i]

     - The provision of an independent and objective opinion to the accountable officer, the board, and the audit committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives; and

     - The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, controls and governance arrangements.

94. Internal audit has widened the scope of its coverage as the breadth of the audit committee role has expanded. To provide a robust head of internal audit opinion, it is important that the risk-based internal audit plan considers the critical business systems underpinning the delivery of the organisation's objectives. In this sense, within the health care sector, quality governance must clearly form part of the assurances received from internal auditors.

95. Some trusts are proactively using their internal audit service to assist in the development of a narrative assurance and escalation framework to provide a clear outline of audit on processes and controls. This may include a baseline assessment of the *Quality Governance Framework* within the organisation or a review of specific elements of the framework, such as:

     - risk management;
     - quality strategy;
     - monitoring and reporting (including KPIs);
     - committee structures (including key relationships between committees such as audit and quality committees);
     - leadership, skills, knowledge, culture, behaviours;
     - quality improvement (including clinical audit); and
     - patient experience.

96. Trusts should consider using audit services to review and provide independent assurance against the trust self-assessment or to facilitate workshops to support the development and embedding of the quality strategy, or specific elements thereof.

Clinical audit

97. Clinical audit – and the high quality, robust and trustworthy data that underpins and is generated by it – is a significant element in trusts' governance of quality. However, current clinical audit practice is highly variable and the use of clinical audit is subject to considerable local interpretation. As such, its relationship with quality governance continues to develop. Areas of good practice do exist and clinical audit can and does work well in certain trusts, particularly where the importance of its contribution is recognised and it is used effectively by boards.

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[i] *Audit Committee Handbook*, HM Treasury, March 2007. http://www.hm-treasury.gov.uk/d/auditcommitteehandbook140307.pdf; *Good Practice Guidance: the consultancy role of internal audit*, HM Treasury, July 2010. http://www.hm-treasury.gov.uk/d/pss_GPG_consultancy_jul10.pdf; and *Public Sector Internal Audit Standards: Applying the IIA International Standards to the UK Public Sector*, HM Treasury, December 2012. http://www.hm-treasury.gov.uk/d/public_sector_internal_audit_standards_december2012.pdf

98. Many trusts use clinical audits, including participation in relevant national audits, as an important tool to help the board obtain assurance on its quality governance. In doing so, boards are deliberately ensuring that clinical audits are aligned both to national audits and the trust's key quality priorities. As such, boards must ensure that they understand the extent to which clinical audit can be used for this purpose or will need to be adapted to reflect priorities and risks. This creates an opportunity to review the role of clinical audit to help align it with clinical effectiveness and clinical outcomes in support of quality assurance.

99. Some trust board members may therefore think that they receive generic assurance over quality governance through the clinical audit and national audit processes. However, it is important to recognise that these are only two facets of quality governance.

100. Although it is not common, a number of trusts are coordinating the internal audit and clinical audit work programmes to ensure that they have adopted a collaborative and cohesive programme that aligns with the quality governance agenda.

Summary

> *The trust board can gain assurance through:*
>
> - *a clearly understood structure of assurance and baseline assessments supporting statements and declarations by the board to regulators.*
>
> - *effective use of the internal audit and clinical audit functions to provide an overview of the quality governance assurances through a systematic review of the assurance processes.*
>
> - *mapping quality improvement strategies to the* Quality Governance Framework *to ensure visibility at the board and within the organisations as to how trust quality activities are aligned with the regulatory regime. This will also assist board-level understanding of the effectiveness of quality governance assurance processes in identifying gaps in the audit and risk escalation processes.*
>
> - *reviewing the audit committee, quality committees and supporting committee structures to ensure that they enhance, not impede, board assurance.*

5. Managing risks to quality

Introduction

101. In the NHS risk is managed at two overlapping levels:

    - Strategic level; and
    - Day-to-day staff/patient operational level.

102. Risk management in health care includes the whole spectrum of things that could and do go wrong. It includes slips, trips and falls involving staff, patients and the public, administrative errors that impact on patient care and clinical incidents, such as medication errors, that have a direct effect on the outcome of patient care. It can include risks as a result of low staff to patient ratios, for example in midwifery, or diagnostic equipment that is in need of replacement. It will also include the management of the business risks associated with running a hospital including financial, ethical and information technology risks.

103. Many boards struggle to assure themselves that managers and clinical units are effectively managing risk. Common areas of challenge include:

    - instilling clinical ownership of risks;
    - capturing all risks;
    - appropriate and consistent validation of risks;
    - learning from incidents;
    - triangulation of complaints, incidents and claims; and
    - the need for a Board Assurance Framework (BAF) to accurately reflect the known top risks to the organisation.

104. The main challenges that have been identified in this area in relation to quality governance are:

    - risk registers;
    - incident recording and escalation; and
    - clinical outcomes versus cost efficiency monitoring.

Risk registers

Board Assurance

- ***Are your BAF and local risk registers effective in capturing the risks to quality within your trust?***

Quality Governance Framework **Good Practice**
1B Is the board sufficiently aware of potential risks to quality?
Including:
- assess and address current and future risks to quality;
- up-to-date risk register, fed by divisions;
- initiatives assessed for quality with clinical sign-off and monitoring;
- clear ownership;
- capturing staff concerns;
- early warning indicators identified;
- post-implementation; and
- mitigating action.

Board Assurance Framework

105. The BAF provides trusts with a simple but comprehensive tool for assessing the effectiveness of their management of the principal risks to meeting their objectives. It should also provide a structure for the evidence to support the Annual Governance Statement. It is designed to simplify board reporting and the prioritisation of action plans, which, in turn, allow for more effective performance management. The main elements are set out below.

Figure 5: Key elements to the Board Assurance Framework

Principal Objectives

Principal Risks

Key Controls

Assurances on Controls

(Management checks, Internal Audit, Clinical Audit, Care Quality Commission, External Audit, Local Counter Fraud Services, NHS Litigation Authority, other reviews)

Board Reports

(positive assurances; gaps in control; gaps in assurance) principal objectives

Board Action Plan

(To improve control, ensure delivery of principal objectives, gain assurance)

106. The first step in preparing a BAF is for the board to identify its organisation's objectives, including its quality objectives. Boards should focus on those that are crucial to the achievement of its overall goals and principal objectives. It is important to balance the strategic and the clinical objectives to ensure that the total impact of risk is assessed.

107. Trust management must ensure that risks are linked to objectives. This should ensure the process brings real value and relevance rather than being a paper or 'tick box' exercise.

108. Many trust boards review and, if necessary, revise the BAF quarterly, while a relevant committee or a sub-committee of the board reviews the BAF and the Corporate Risk Register monthly. In conducting the review, trusts should ensure that the BAF directly links to the strategic and quality objectives, with assurance as the achievement of the latter being supported by the Quality Committee in addition to the Audit Committee.

Local Risk Registers

109. It is essential that boards understand that they need to assure themselves that risks are being appropriately managed, rather than reacting to the consequences of risk exposure. In order to ensure that the board has visibility of risks as they emerge, trusts should ensure the efficient development of clinical unit risk registers through local risk escalation. They should have a risk management policy that sets out the trust's approach to risk management.

110. External assessment of risk management such as CQC inspections and NHS Litigation Authority (NHSLA) standards and ratings can help drive improvements in risk management and are prominent on board agendas.

111. All staff should be aware of the clinical unit risk registers and those managers with responsibility for risk will need to be supported by training. Effective trusts have put in place training programmes for managers to ensure that there is a good understanding of risk management and escalation, supported by consistent use of tools and local risk registers across the entire trust. Local governance meetings feeding into the Audit Committee and Quality Committee should ensure that they seek assurance that the risk ratings are correct and that actions to reduce the risk have been identified and are being addressed.

112. Board members should be aware of the risk escalation process at and beneath clinical unit level. Risk management frameworks should explicitly outline the processes for local risk management. The trust processes should incorporate regular review and reporting of local risk registers to the corporate risk register. These processes should include mechanisms for assuring the board on risk registers, reporting on the effectiveness of local risk registers and be supported by local audit. Local risk registers should be managed and monitored within a risk register library or directory, with risk logs updated by a central coordinator. As visibility of local risk registers can be challenging, some trusts have incorporated into their internal audit programme a regular review of the completion of local risk registers including the correlation between the local risk registers, the corporate risk register and the BAF.

113. Clinical unit leaders should be responsible for local risk registers and should report any corporate risks directly to the appropriate sub-committee of the board. They should be responsible for ensuring the maintenance of risk assessments and registers and that these are cascaded to all employees. This responsibility should encompass carrying out root cause analysis of Serious Untoward Incidents (SUIs), using Global Trigger Tools and ensuring that lessons learned are shared. It is important that trusts are able to 'close the loop' through developing action plans to address issues and ensure that these are implemented.

114. We found boards that consider the following approaches to ensure that there are effective systems and processes in place to understand current and future risks to quality:

- Maintaining oversight of risks to compliance with essential standards, such as CQC standards;
- Reviewing the risk estimates contained in CQC Quality and Risk Profiles and following up underlying issues;
- Reviewing ongoing performance in national clinical audits, clinical registries, clinical services accreditation schemes and related national quality improvement initiatives. These provide data that permits comparison with other providers;
- Setting minimum common standards and assuring the board that these are not being compromised;
- Reviewing patient safety incidents from within the trust and wider NHS and 'near misses' to identify similarities or areas for organisation-wide learning;
- Receiving assurance on headcount implications of CIPs through review of, for example, the National Workforce Assurance Tool; and
- Reviewing the learning from complaints, claims and Rule 43 coroner reports.

Incident recording and escalation

> **Board Assurance**
> - *How assured are you that patient safety incidents are being reported and dealt with correctly and escalated to the board appropriately?*

> *Quality Governance Framework Good Practice*
> **3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?**
> Including:
> - escalation processes understood, governed and documented;
> - action plans supported by ownership, delivery and follow-ups;
> - learning shared and implemented;
> - impactful clinical and internal audit processes in relation to quality governance;
> - 'whistleblower'/error reporting process; and
> - effective performance management system.

115. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded health care. Unless trusts are confident that their reporting systems identify the main risks to patient safety they cannot target interventions effectively. Within local organisations strong leadership and governance at chief executive and board level is crucial.

116. Many incidents arise as a result of a system failure rather than individual mistakes, but this will only become clear if the organisation adopts an effective approach to root cause analysis and maximises the learning opportunity.

117. The National Patient Safety Agency (NPSA) developed comprehensive guidance on the risk categorisation of patient safety incidents and on how to improve the reporting and learning culture. NHS England has taken on operational patient safety responsibilities including providing overall strategy for patient safety, providing guidance for commissioning and provision of safer care through the use of data via the National Reporting and Learning System (NRLS).

118. The definition of an incident is very wide-ranging and staff often find it difficult to know what to report, particularly for less serious incidents. Staff should be made aware of the importance of reporting incidents and the processes involved. This needs to be set out in their induction training and reinforced in, for example, quality updates, communications from the executive and in their appraisals. Many trusts ensure that a duty to comply with the policy on incident reporting is clearly set out in staff terms of employment and that induction training incorporates training on risk and incident reporting. Boards increasingly receive reports on the 'take up' and effectiveness of induction training.

119. The majority of trusts utilise a tailored incident recording and reporting system, such as Datix, to link to the mandatory NRLS, minimising diverse systems and reducing the requirement for manual reconciliation or manipulation. Feedback reports from the NRLS are an important benchmarking tool for trusts.

Clinical outcomes versus cost efficiency

> **Board Assurance**
> - *How are you assured that efficiency programmes are not adversely impacting on the quality of patient care?*

> *Quality Governance Framework* **Good Practice**
> **1B Is the board sufficiently aware of potential risks to quality?**
> - assess and address current and future risks to quality;
> - up-to-date risk register, fed by divisions;
> - initiatives assessed for quality with clinical sign-off and monitoring;
> - clear ownership;
> - capturing staff concerns;
> - early warning indicators identified;
> - post-implementation; and
> - mitigating action.

120. All staff should have an understanding of the potential risks to quality as a consequence of CIPs. It is important that staff are given the opportunity to identify where financial savings may impact on quality and raise concerns accordingly. To that end, the development of CIP schemes should begin at clinical unit management level. However, it should not exist only at this level and clinical units should ensure that there is formal ownership and establishment of the schemes down to individual level where relevant. Monitor issued guidance to trusts on CIPs in January 2012[I] and in July 2012 the National Quality Board published its guidance in this area, *How to Quality Impact Assess Provider Cost Improvement Plans.*[II]

121. **Raising concerns:** Front-line staff should be explicitly told that they should raise concerns where they feel quality is being compromised as the result of cost improvements or efficiencies. There should be a clear process to raise concerns on CIPs. It is important that the formal solicitation of staff views is not a 'tick box exercise'. Formal board visits to clinical units and discussions with staff should formally solicit views on the effectiveness of both the Quality Impact Assessment (QIA) process and the impact of the delivery of CIPs on the quality of care.

122. Many trusts have introduced efficiency programmes based on Lean Thinking,[III] Productive Ward and Productive Operating Theatre series to allow staff to contribute to the identification of efficiencies within the trust.

[I] *Delivering sustainable cost improvement programmes*, Monitor, January 2012.
http://www.monitor.gov.uk/cips

[II] *How to Quality Impact Assess Provider Cost Improvement Plans*, National Quality Board, July 2012.https://www.wp.dh.gov.uk/health/files/2012/07/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

[III] *Lean Thinking and the Productive Series*, NHS Institute for Innovation and Improvement.
http://www.institute.nhs.uk

123. **Quality Impact Assessment:** This process should be used for all productivity and efficiency schemes and can be used across several schemes rather than a separate one for each. The QIA should cover all functions of quality, including safety, effectiveness and outcomes. Frontline staff, including consultants and junior doctors, should contribute to assessing CIP schemes. Many trusts ensure consistency in QIA risk assessment tools by formally engaging clinicians to assess potential impacts on quality and safety. Such tools might typically include:

   • target cost reduction;
   • risk appetite;
   • quality indicators including patient safety, mortality, infection control, incidents, patient satisfaction, staff satisfaction and mandatory training;
   • governance indicators: for example A&E standards, waits for admission, cancelled operations, delayed transfers of care, emergency readmissions and lengths of stay;
   • a brief description of potential impact, and where negative, possible mitigation; and
   • the overall chance of negative or positive impact on quality indicators.

124. **Post-implementation review:** Large CIPs, or those that may carry a higher risk of impacting on quality, should incorporate explicit plans for a proportionate and systematic post-implementation review. The extent of coverage of these schemes should be proportionate to the level of cost-cutting challenge faced by the trust. Many boards will use their quality committee to receive an aggregated view of the impact of CIP post-implementation, conducted at clinical unit level. Aggregation at trust-wide level may also be beneficial as the cumulative impact of CIP schemes is sometimes not fully taken into account.

125. Some trusts have put in place CIP Boards that are responsible for monitoring implementation of the CIPs and are chaired by either the Medical Director or the Director of Nursing to ensure they are not purely financially focused. The CIP Board should include non-executive director representation and/or be monitored by the quality committee. Often both the Medical Director and the Director of Nursing and Quality will be responsible for signing off each CIP QIA and, importantly, fully understanding what is being agreed.

126. **Reporting:** The reporting of CIPs at board level should plainly demonstrate clear metrics and discussion of the impact on quality of the efficiency programme. Board performance reports should explicitly link quality performance to the CIPs to ensure detailed analysis of impact allowing effective scrutiny by the board. Reporting on CIPs should include clear metrics or scoring to monitor the impact of schemes on quality. This should support board members' triangulation of quality information. The Integrated Board Report should directly link the reporting of CIP financial targets with the underpinning quality metrics. Some trusts will use regular reporting of capacity and capability, linking variances to the related CIPs.

127. Local reports and insight into front-line services are essential when monitoring key governance and quality indicators around CIPs. Local indicators such as staff sickness, failing to close down incidents in a timely manner, increase in sickness and absence and complaints are vital to understand the unintended consequences of CIPs.

Summary

The trust board can gain assurance through:

- *identifying and addressing risks to trust quality objectives through regular review of the BAF and risk register, underpinned by a robust risk management framework.*

- *implementation of an audit programme that includes regular review that local risk registers are being completed correctly. Audit activity and risk management processes can be significantly enhanced through the use of risk management and incident reporting software systems if supported by risk management expertise and effective reporting to the board.*

- *increased incident reporting, supported by clear guidance on risk categorisation and staff training and culture. This should be triangulated with related management information such as complaints, Patient Advice and Liaison Service (PALS) activity, staff training and risk identification.*

- *CIP schemes beginning at clinical unit and ownership existing at individual level are based on effective and transparent QIAs, reporting and post-implementation review. Boards have visibility of staff involvement in CIP and associated risk identification and peer review of impact on services.*

- *staff know how and are able to raise concerns where they feel quality is compromised.*

Appendix A: Detailed questions supporting quality governance assurance for boards to consider[I]

Boards may wish to use the detailed questions below to help compare their quality governance assurance activity with the domains of the *Quality Governance Framework*.

Question:	Evidence Yes / No	Link to *Quality Governance Framework* domains
Engagement on quality: • *Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve?* • *Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership? What is your evidence for this?* • *Does the board understand the effectiveness of the methods used by the trust for communicating to and involving staff, patients and stakeholders in the quality agenda?*		

1. The board has put in place a leadership development programme that:
  • reviews the skills and capabilities of the board in relation to quality governance;
  • demonstrates learning and impact on behaviours;
  • considers the skills of non-executive directors in relation to quality governance;
  • encourages and trains clinical leadership and non-clinical management to participating in setting the quality agenda; and
  • identifies and develops future leaders.
		1A: Does quality drive the trust's strategy?
		2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?
		2B: Does the board promote a quality-focused culture throughout the trust?
		3C: Does the board actively engage patients, staff and other key stakeholders on quality?

2. The board encourages the development of an open and quality culture through:
  • a participative approach to staff and clinical engagement;
  • the investment of resource to promotion of the change; and
  • the use of quality walks, surveys and peer reviews.
		2B: Does the board promote a quality-focused culture throughout the trust?

3. The board has developed its quality improvement strategy through:
  • the creation of systematic processes for engaging staff in development, communication and devising indicators;
  • involvement of commissioners, partners, patients;
  • analysis of the organisation's performance on key quality indicators;
  • directly linking the Quality Accounts with the quality improvement strategy.
		1A: Does quality drive the trust's strategy?
		2B: Does the board promote a quality-focused culture throughout the trust?
		3C: Does the board actively engage patients, staff and other key stakeholders on quality?

[I] These are intended to support the good practice set out in the *Quality Governance Framework*.

4. The board applies good principles of effective staff engagement such as: • considering harder to reach staff; • actively considering how staff will be engaged in strategic and service development; • communicating data and information that the board receives to the relevant staff; • ensuring that staff know how to raise issues; and • seeking out and reviewing the results of staff feedback using regular 'local' staff surveys.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?
5. The board uses the following principles to ensure effective engagement with the public: • uses public consultation to shape strategy and process design; • uses a wide variety of methods to engage a cross-section of the public; • promotes a culture of communication; and • feeds back the outcomes from engagement and consultation.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?
6. The board uses patients to design improvements, and monitor whether they have the desired impact through an approach that includes: • capturing a broad range of patients and carers; • embedding patient engagement and involvement into the quality improvement programme; • including patients in service and process redesign; • ensuring engagement processes are user-friendly; • encouraging staff to take ownership by leading responses to patient engagement; and • ensuring patient feedback demonstrates impact.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?
7. The board engages with commissioners and partners through: • proactive and early consultation; • ensuring that commissioners' views are considered in setting and monitoring quality goals; and • collaborating with local authorities and GPs on quality improvement strategies.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?

Gaining insight and foresight into quality:

- *How are you assured that the board is receiving the right type and level of quality information?*
- *Have you compared the information you receive with other trusts of similar type and complexity?*
- *Are the 'hard' facts and data consistent with what you are hearing and observing around your trust?*
- *How are you assured that the data you use to inform decisions is robust and valid?*
- *Could you name the best and worst performing services from a quality perspective within your trust and how these services compare with other trusts?*

8. The board uses a strategic integrated performance dashboard which includes: • quality, performance, activity and finance; • aligning performance scorecards to strategic goals; • expanding to ward- and service-level dashboards; • explanation for variances; • analyses and comments; • performance projection and trends; • risk analysis on achieving trajectory; and • overview summary of the impact on quality by division or service.		4A Is appropriate quality information being analysed and challenged? 4C Is quality information used effectively?
9. The board has a strategic approach to data quality which drives quality improvement with: • SMART objectives; • data quality metrics; and • data quality assurance and audit programme.		4B: Is the board assured of the robustness of the quality information?
10. The board benchmarks performance: • with comparable organisations where possible; • based on risk assessing greatest need; • using internal benchmarking and 'peer reviews'; and • analysing historical data.		4A Is appropriate quality information being analysed and challenged? 4C Is quality information used effectively?

Accountability for quality:

- *What are the key sources of assurance upon which you rely?*
- *Are you able to distinguish between assurance and reassurance?*
- *Is there a clear trail of assurance underpinning the board statements and declarations?*
- *Do you understand how quality governance assurance processes operate across the organisation's committee structure?*
- *Do you understand the role that your audit functions have in supporting board assurance on quality governance?*

11. The board supports its Corporate Governance Statement on quality and quality governance through: • a clearly understood structure of assurance and baseline assessments supporting statements and declarations by the board; • utilising the internal audit function to provide an overview of the quality governance assurances; • mapping quality improvement strategies to the *Quality Governance Framework* to ensure visibility at the board and within the organisation as to how the trust's quality activities are aligned with the regulatory regime and the coverage provided by the audit and risk escalation processes.		1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance?
12. The board has effective supporting structures to enable the board to carry out its role efficiently by: • ensuring that the committee structures can demonstrate that the quality governance agenda is being adequately covered; • reviewing the tiers of supporting committees to ensure that they do not impede board assurance; • ensuring that clinical quality remains a core feature of mainstream reporting at board level; • reviewing the effectiveness of the role of the audit committee and other board committees to ensure that the systems and process are functioning effectively in relation to assurance; and • clearly setting out the roles and terms of reference of each committee and sub-committee in relation to assurance on quality governance.		1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
13. The board effectively uses audit functions to support quality governance assurance by: • developing a narrative assurance and escalation framework to provide a clear outline of audit and assurance of processes and controls; • using audit to conduct baseline assessments or specific elements of the *Quality Governance Framework* within the organisation; • using audit to review and provide independent assurance against the trust's self-assessment; and • ensuring that the internal audit and clinical audit work programmes are collaborative and cohesive and aligned to the quality governance agenda.		1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?

14. The board has taken steps to ensure that it can identify and address the risks to its quality objectives: • the BAF should be reviewed and if necessary revised quarterly; • the risk management frameworks explicitly outline the processes for local risk management and registers; • board members are aware of the risk escalation process at and beneath clinical unit level; • management and staff with responsibility for risk are supported by training; • local risk registers are supported by local audit and a centrally coordinated risk register library; and • there is an audit programme of regular review of the completion of local risk registers.		1B: Is the board sufficiently aware of potential risks to quality? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
15. The board uses good practice to improve incident reporting by: • issuing clear guidance on risk categorisation of patient safety incidents and reporting; • staff trained and inducted on the importance of reporting incidents and the processes involved; • a duty to comply with the policy on incident reporting is set out in staff terms of employment; • using a tailored incident recording and reporting system to minimise manual reconciliation or manipulation; and • reporting increases in incident reporting to the board.		1B: Is the board sufficiently aware of potential risks to quality? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
16. The board ensures that it understands the potential risks to quality as a consequence of CIPs by: • ensuring that development of CIP schemes begins at clinical unit management level and ownership is cascaded down to individual level; • informing staff that they should raise		1B: Is the board sufficiently aware of potential risks to quality?

concerns where they feel quality is being compromised as the result of cost improvements or efficiencies; • implementing a QIA to support the identification and mitigation of risks and ensuring this is linked to local risk registers; • carrying out post-implementation review of CIPs carrying a higher risk of impacting on quality; and • reporting CIPs at board with clear metrics showing the impact on quality of the efficiency programme.		

Appendix B: Acknowledgements

Monitor commissioned Deloitte LLP to develop this guidance in conjunction with key partners and stakeholders from across the NHS.

The inclusive approach to co-design consisted of:

- consultation with Monitor;
- consultation with a range of stakeholders and focus groups: including Monitor's Compliance and Assessment teams, internal audit providers and trusts selected to provide a cross-section of perspectives from acute, mental health, community and ambulance sectors. The trusts were consulted to inform understanding of current internal assurance mechanisms and identification of potential improvements areas;
- an 'Editorial Panel' formed from the NHS, academia and regulators to provide insights and expertise and peer review the draft iteration of the guidance; and
- a review of key quality governance good practice publications and global literature and developments, including Monitor's *Code of Governance* and *Compliance Framework*.

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- Lewisham Healthcare NHS Trust
- NHS London
- Nottinghamshire Healthcare NHS Trust
- Royal Free London NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- University Hospital of South Manchester NHS Foundation Trust
- Mersey Internal Audit Agency
- KMPG LLP
- Deloitte Public Sector Internal Audit

Appendix C: Glossary

A-Z listing of terminology, organisations and definitions used in the guidance.

Annual Governance Statement
All NHS trusts and NHS foundation trusts are required to provide assurance about the stewardship of their organisations to the NHS Chief Executive, and should include this governance statement in their annual report and accounts.

The Board Assurance Framework (BAF)
This is a mechanism which boards should use to reinforce strategic focus and better management of risk. It is designed to be a simple yet comprehensive method for the effective and focused management of the principal risks to meeting their objectives.

Boards on Board Programme
Hosted by the North West Leadership Academy designed to support trust boards in developing system-wide programmes of improvement and using metrics. It is delivered by the Institute for Healthcare Improvement (IHI), and by the Advancing Quality Alliance (AQuA).

The Care Quality Commission (CQC)
This is the independent regulator of all health and social care services in England. CQC inspectors visit health and adult social care services to check that they are meeting national standards of quality and safety.

Dr Foster Hospital Guide
Dr Foster is a provider of comparative information on health and social care services. Dr Foster publishes a Hospital Guide analysing the quality of care provided in the NHS. This includes ratings of clinical efficiency and online interrogation tools.

Global Trigger Tool^{TM}
The Institute for Healthcare Improvement has developed a Global Trigger Tool^{TM} for measuring adverse events. The NHS Institute for Innovation and Improvement (now NHS Improving Quality) has the Acute Trigger Tool as an approved UK version.

The Integrated Business Plan (IBP)
This is the main working document forming the plans for a trust's activity over a five year period. It will include strategic goals, market assessment, service development, financial planning and the risks to these plans.

Manchester Patient Safety Framework
The Manchester Patient Safety Framework is a tool designed to help NHS trusts assess their progress in developing a quality culture, focusing on the dimension of patient safety.

Medical Engagement Scale
The NHS Institute for Innovation and Improvement commissioned the Medical Engagement Scale as a measure of medical engagement that would provide information about the cultural environment of the organisation. It is designed to help NHS trusts evaluate levels of medical engagement and develop strategies to improve it.

The NHS Litigation Authority (NHSLA)
It provides indemnity cover for legal claims against the NHS, assists the NHS with risk management and shares learning about risks and standards.

The National Patient Safety Agency (NPSA)
It aims to identify and reduce risks to patients receiving NHS care. It leads on national initiatives to improve patient safety, including incident reporting. From 1 June 2012 its key functions for patient safety transferred to NHS England.

National Quality Dashboard
The National Quality Dashboard is being developed jointly between NHS England, the NHS Trust Development Authority, CQC and Monitor. This dashboard is available to local Quality Surveillance Groups to assist in providing a picture on quality within NHS provider organisations.

National Reporting and Learning System (NRLS)
As part of NHS England, the NRLS is a system enabling patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

Patient Reported Outcome Measures (PROMs)
PROMs assess the quality of care delivered to NHS patients from the patient perspective. They currently cover four clinical procedures (hip replacements, knee replacements, hernia and varicose veins) and calculate the health gains after surgical treatment using pre- and post-operative surveys. This approach has been used by all providers of NHS-funded care since April 2009.

Productive Operating Theatre
The NHS Institute for Innovation and Improvement (now called NHS Improving Quality) developed the Productive Operating Theatre programme (a modular improvement programme) with NHS organisations to help front-line theatre teams play their part in delivering identified Quality, Innovation, Productivity and Prevention (QIPP) savings. It has found that focusing on quality and safety helps theatres to run more productively and efficiently.

Productive Ward
The Productive Ward - Releasing Time to Care was developed by the NHS Institute for Innovation and Improvement. It focuses on improving ward processes and environments to help nurses spend more time on patient care, thus improving levels of safety and efficiency.