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Brighton and Sussex University Hospitals NHS Trust

Quality governance review

Final report from the Good Governance Institute

November 2017


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Brighton and Sussex University Hospitals NHS Trust
Quality governance review

Final Report

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Executive summary

This report has been produced at a pivotal time for the trust, both in terms of corporate and clinical governance. In the relatively short time that we have been engaged with the trust, we have been impressed with the pace and focus of the new senior leadership team in addressing the many challenges that Special Measures status has highlighted.

Set out below are some 30 recommendations designed to support the trust on its governance journey which will require significant training and development from board to ward. We have clustered the recommendations around core themes for ease of reference which are expanded upon within the body of the report.

Leadership and strategic direction

R1 The trust management should agree and publish what they mean in terms of 'earned autonomy' as it relates to governance at the divisional level. For consistency, we would suggest this is tied into an incremental improvement against the relevant maturity matrix

R4 A skills and capability review of all individual directors should be carried out against the NHS board directors' competencies matrix. The results should be fed into a succession plan for the board and any future board development plan

R5 Chairing board sub-committees is a critical task and the trust should only appoint experienced individuals with sufficient skills and knowledge to chair board sub-committees'

R9 The board should consider and agree its risk appetite for each strategic objective, in order that this can guide the development of controls and assurances

R10 The board's schedule of delegation and reservation should be reviewed in the light of the recommendations to change the trust's quality management structure

R17 The board should assess itself against the NHS trust board maturity matrix, and have as a development aspiration to reach at least level 3 by the end of March 2018

R28 The trust should identify how clinical governance will be led and resourced going forward. Options could include the 'separate central and divisional capacity' model of the 'matrix working' options that we have described

R31 The trust board should receive a progress report against this report's recommendations in April 2018

Risk management and assurance systems

R3 The BAF should be re-written and should be worked on and agreed by the board as part of board development. The new BAF should be explained to the newly-appointed divisional triumvirates, and in particular, the assurance framework should be the script for the quality management system of the trust

R15 The cycles of business for the new quality governance steering group and the four new quality assurance committees should be linked to the BAF

R16 The next annual board sub-committees' review should test whether the board are content with the level of assurance each sub-committee is providing, and how this supports the BAF

R21 The structure of the corporate risk register, particularly in relation to action plans, should be reviewed

R22 Whilst the risk management strategy was agreed in 2016, it is flawed and will not reflect the current quality management structure. It needs to be replaced by the end of March 2018

Patient safety

R23 The new Patient Safety Group should maintain a watching brief on incident reporting levels with the aim that these match the appropriate national norms within 12 months

R24 Incident investigation skills should not reside in a small central team. A much wider pool of incident investigators should be developed and used

Clinical effectiveness

R2 To signify individual responsibility for clinical governance, all job descriptions for clinical leaders, the triumvirates within the divisions, clinical directors and specialty leads should include specific reference to accountability for clinical governance. All appraisal and personal development planning should support this, with specific goals for all relevant members of staff

R19 The clinical governance capacity and capability of the trust should be developed to achieve level 3 on the clinical governance maturity matrix by the end of March 2018

R25 A new clinical effectiveness strategy should be developed and agreed by the end of March 2018 and this should incorporate national best practice as aspirations for the clinical audit programme

R27 To support the divisions develop a high standard of clinical governance from the outset, a 'development by doing' programme (as set out at Appendix I) should be delivered

Patient experience

R26 A patient experience strategy should be developed and agreed by the end of March 2018

Staff engagement

R18 There should be an at-scale communications programme to help staff understand the new quality assurance system, to include basic clinical governance expectations such as incident reporting, the risk management system, the Duty of Candour and patient experience

Quality management structure

R6 The new recommended quality management structure should be implemented (i.e four new quality assurance groups reporting to a new quality governance steering group)

R7 No management groups should report to board sub-committees'. All management groups should have reporting lines up through management. The assurance role of board sub-committees', organised through the BAF, should be emphasised

R8 Any new governance arrangements should be considered in terms of scalability within a group structure

R11 The term 'committee' should only be used for those committees that directly report to the board

R12 Board sub-committees' should be limited to audit, remuneration and appointments, quality, finance and investment and charitable funds. All other sub-committees' of the board should be time-limited task and finish groups

R13 As part of management's review of the 3Ts programme, consideration should be given to recommending that this current board-reporting group should become a task and finish group

R14 The cycles of business for the board and all sub-committees' should be linked to the BAF

R20 Any 'feeder groups' should be formally related to one of the quality assurance groups

R29 The governance meetings matrix should be adopted to support the divisions and clinical directorates better deliver their governance accountabilities

R30 The roles for the quality and audit committees should be developed along the lines described in figure 1. Internal audit should have sight of this report to support their work in regard to quality governance as part off the annual programme of internal audit

1. Background

1.1 Brighton and Sussex University Hospitals NHS Trust (BSUH) provides district general hospital services to the local populations in and around the Brighton and Hove, Mid-Sussex and the western part of East Sussex, and more specialised and tertiary services for patients across Sussex and the south east of England. Working across two main sites: Royal Sussex County in Brighton and Princess Royal in Haywards Heath, BSUH treats over three quarters of a million patients each year and employs over 8,000 members of staff.

1.2 The trust is undertaking a major building programme to modernise and replace its estate. Focusing on tertiary, teaching and trauma, this £486m '3Ts' re-development programme is estimated to be completed in 2024, and represents the opportunity to improve services for local people and for those, both local and across Sussex, who require access to more specialised services.

1.3 BSUH are currently rated 'inadequate' by the Care Quality Commission (CQC) following the publication of an inspection report in August 2016[1] and are in the special measures improvement regime. As at October 2016, the trust have also been placed in financial special measures by NHS Improvement (NHSI), given the trust's negative variance against the control total plan and the forecast deficit level for 2016/17. Given this context, BSUH have now signed a management agreement with Western Sussex Hospitals NHS Foundation Trust (Western) and NHSI, creating an interim arrangement between the two trusts to begin a new way of working together. The arrangement includes supporting the trust to deliver on its requirements under both types of special measures.

1.4 From April 2017, new board and management arrangements came into effect. The executive posts for both BSUH and Western were combined expeditiously so that each trust had the same management team, although each trust will have its own chief operating officer (COO). The Chair of Western became the Chair of BSUH, and the BSUH board was strengthened by appointing two of the Western non-executive directors to the board. All other Western non-executives became associate non-executives of BSUH, and all BSUH non-executive directors became associate non-executive directors at Western. In short, though remaining two legal entities, the same individuals sit round the board table for each trust, with the exception of the two planned COOs who individually sit on the BSUH board and the Western board.

1.5 One of the priorities for the new management team was to address the CQC recommendations, including the strengthening of the governance systems of the organisation. GGI were appointed to start this process by undertaking a governance review that focused on the clinical aspects of the corporate governance arrangements of the trust, but with a developmental focus. The new management team were less concerned with historic governance matters that had been part of the issues facing BSUH, and more with what new governance structures, processes and ways of working should be put in place to best support transformational change and improvement.

1.6 In developing new governance arrangements, the management team, and both trust boards, need to think through the implications for scaling of any new system they adopt. There are useful lessons and good examples from Western, where the CQC have given a rating of 'outstanding' that are expected to benefit BSUH. However, governance arrangements need to be deliverable within what is effectively an emerging group structure for however long the management contract remains in place.

1.7 The GGI review was undertaken between September and early November 2017. During this time, the new management team were preparing and starting to institute new managerial arrangements within the trust, and so GGI were not looking at a fixed operational system but one under radical change. This usefully emphasised the developmental aspect of the review, and we were encouraged to focus on, in particular, the quality governance aspects of the overall governance arrangements. The implementation of the new divisional structure is a very significant change now being put in place. It is a significant plank of the new structural and cultural arrangements upon which the transformation agenda depends.

1.8 GGI briefed the trust's management team in late October 2017 on the main themes and findings arsing out of this review, and requested that the key developmental steps to support the trust ensure that good governance was 'hard-wired' into the emerging new structures and systems be included in the report. For this reason, we include in the report a section of the developing divisional structure, which is a new and developing element of the overall governance arrangements and just in the planning when we started our work.

1) Care Quality Commission, 'Brighton and Sussex University Hospitals NHS Trust' Care Quality Commission Care Quality Commission August 2016

2. Methodology and approach

2.1 The review was undertaken between September and early November 2017, using a well-established review technique that has as its basis the triangulation of evidence gathered in a variety of ways. This overall approach is standard, and in line with the standard for Well-Led Reviews set out in NHSI guidance[2] of June 2017. The main review activities undertaken at BSUH were:

- Observation of key meetings
- Document review
- Confidential one-to-one interviews with internal staff

2.2 GGI's review process used a range of materials, tools, templates and benchmarking tools to guide various review activities, which include in this instance:

- NHS trust board governance maturity matrix[3]
- Clinical governance maturity matrix[4]
- Development and improvement of quality and clinical governance within divisions[5]

2.3 We were also informed by the NHS directors' competency matrix[6], although we were not asked as part of the review to include an individual review of all directors at this stage.

2.4 The GGI review team comprised two senior directors, an assistant director and a senior associate who specialises in healthcare quality and patient safety. The majority of the on-site work was conducted in September and October 2017.

2.5 In constructing this report, we have triangulated findings from various evidence sources, and used the senior experience of the review team to assess the relevance and significance of observations and data we collected. The team used established templates, matrices and literature as well as (and importantly) professional knowledge, peer experience and review expertise to demonstrate the significance of the findings against good governance practice.

2.6 It was very clear that the system we were attempting to measure was rapidly being changed by the new management team, and the old ways of working had no overall champions resisting this change. Indeed, most of those we interviewed were able to invest hope and confidence in the new leadership team. All were interested in moving forward rather than looking back. The main emphasis, therefore, of how we have carried out this review and presented our report is very much focused on how we recommend governance is developed over the coming months, rather than describe the issues and problems that we observed. This being said, good work had been done on aspects of clinical governance prior to the new management coming in, but the report will later describe how what good work there had been done nevertheless was unable to gain sufficient grip or depth to address the quality issues. Hence the trust found itself as rated 'inadequate'.

2.7 We were firmly of the view that the new management had quickly grasped the trust's problems and were rapidly addressing these. There was little merit in repeating many familiar governance issues back to the new management. For this reason, we have summarised the main issues that we believe need to be prioritised, and have outlined the practical recommendations required to be adopted in moving forward. Recommendations are all listed in the last section of this report, but are referenced in the text too with an 'R' followed by the recommendation number in brackets.

2) NHS Improvement, 'Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts', NHS Improvement, June 2017
3) Smith C et al; 'NHS Trust Board Good Governance Maturity Matrix'; Good Governance Institute, London; August 2017 ISBN: 978-1-907610-43-1
4) Merrett H et al; 'Clinical governance maturity matrix'; Good Governance Institute, London; November 2017
5) Corbett-Nolan A et al; 'Quality and clinical governance within divisions'; Good Governance Institute, London; October 2016
6) Corbett-Nolan A; 'NHS Directors' Competencies Matrix' Version 1.0; Good Governance Institute, London; June 2015

3. Governance and management issues

3.1 BSUH's recent history has been characterised as having had more than half a decade of continual leadership change. This has included chief executive tenure from some of the better-known NHS chief executives, each of whom have striven to solve the trust's performance and quality issues in their own way. They have needed to negotiate their way through various forms of regulator intervention as they each sort to find their way of solving the longer-standing issues. Whilst not a unique scenario for troubled NHS trusts, the constant leadership change at BSUH has been extreme and we suggest damaging. With regard to the trust board, only several of the current non-executives pre-date the current special measures. This on-going change has had a significant impact on the culture of the organisation and brought about specific management challenges that the new team are now seeking to address. We highlight below some key governance issues:

a) Corporate history issues leading to entropy

In the leadership team, there is very little by way of corporate memory. This is in some ways both an advantage and a problem for the new leadership. One tier down there is considerable ennui within some (but not all) longer-serving members of staff who have 'seen it all before'. They have been trying to keep going and maintain the hospitals functioning whoever is currently in charge. This is perfectly understandable, even commendable, but does give the new leadership the challenge of convincing those who will manage and deliver the required change that this time the changes are definitive and will be followed through on.

There is a real 'hump' to overcome in terms of staff perceptions formed as a consequence of years of poor findings from the regulator that not meeting targets, managing within budgets or following through on agreed commitments and actions is normal, even permissible. We would emphasise that we attribute this behaviour to an eroded sense of confidence, rather than forgetting that the interests of patients must come first.

b) Centralisation vs. local ownership

Despite what has effectively been listlessness from previous management regimes, one clear philosophical approach that had emerged has been one of centralisation of control and focus around clinical governance issues. Whilst this has led to some quite thorough work around particular clinical governance issues, this has not been sufficiently impactful due to the lack of local ownership and because of ineffective dissemination. The new leadership, through a planned system of earned (but required) autonomy, are putting in place a model that intends to build strong local ownership and control. (R1) This is the precise opposite of the approach to date. The new local leadership for BSUH (the soon to be appointed CCO and team) have an essential core task to build up the divisions and emphasise accountability through effective line management.

c) Responsibility for solving problems

In sympathy with the above, although difficult to evidence tangibly, is the lack of appreciation from staff of the need to 'own' both problems and find solutions at the local level. A consistent theme arising out of our interviews with staff, who had been in post over several regimes, was a sense that they were commentating on what had happened without there being a sense that they were involved. We noted that corporate documentation was often of a high standard, articulately describing the trust's decline and with little comment on what management grip was being exerted in order to address the major issues of performance delivery. (R2)

d) Lack of joined up working

We have observed what we can only describe as idiosyncratic, siloed and un-standardised working practices in the different clinical governance disciplines and between clinical directorates. We met with some very able and committed individuals who had worked hard, but they had not been supported by an overall system whereby all the dots joined up to create one understandable quality system. The interim managing director (post being replaced by a COO) had done much to standardise reporting, and as the transition to the new divisions takes place, there is a good opportunity to extend this into the new structure. The overall purpose of the quality system was often described to us as satisfying the regulator rather than as a means of managing the delivery of better patient care within the available resources.

e) Multiple governance groups and meetings

In parallel, there has been an accretion of central management groups addressing various, often over-lapping, quality management issues. Because there is not now a single, well-designed and understandable quality system, participation in these groups has been unrewarding to those attending and so attendance and momentum is poor. We could not identify one individual who could name the various quality management groups, and real confusion exists about the way in which the groups all fit together. We were shown many variants of organograms for these groups, but no single version of the truth existed

f) Quality management basics

There is a conflation of quality assurance and quality improvement, with the same forums often being used to attempt both. Almost entirely absent is an understanding that the ultimate customer for the quality assurance activity is the board, and that through the board assurance framework (BAF), specific and codified quality governance activity is needed to support the board in its assurance and scrutiny role. (R3) Whilst there is an understanding of upwards escalation (and indeed, this could be characterised as over-enthusiastic at times) there is no accompanying understanding that a main purpose of the clinical governance activity was to achieve board to ward oversight and assurance. Quality management training, when it has happened, has often emphasised improvement techniques rather than a more holistic understanding of the distinctive role of assurance. There is a very poor record of developing and then following up on action plans. Linkages are also not being made between what the different quality performance data is showing, with the accompanying higher-level developmental themes being missed.

g) Clarity of and competence/experience within key roles

There has been confusion between governance and management, and as a result, a blurring of the respective roles of the board and of the executive. This had been either caused, or at least accelerated, as a consequence of the board stepping in during the prior year because of what was described to us as a collapse of managerial control. The result is that structures and working methods are in place that do not help the trust benefit from the added value that board oversight should be bringing. This blurring has become normalised.

A principal duty of a director is to understand the organisation they are governing and the market in which they are operating. Quality management in healthcare is complex, and the skills required by non-executives to ask the right assurance questions and understand when an answer does indeed provide assurance usually needs developing for those without relevant experience. The chair of `clinical governance-related board sub-committee needs to be able to systematically and point by point agree the agenda, accept assurance papers and then to take the sub-committee through their work so as to ultimately provide the board with assurance.

Particularly within what is effectively developing as a hospital group, seniority in the director role and experience of the subject matter is essential to discharge this responsibility in a trust with as many challenges as BSUH. We have not yet tested in a formal sense the skills, experience and capabilities of the board members individually but on the basis of what we have seen not only are the governance and managerial roles confused, but we cannot confirm that we saw sufficient experience and understanding within all the non-executive directors for us to say that the relevant skills and abilities to undertake such tasks are in place. (R4) This trust needs, in our opinion, experienced and senior non-executive directors that are fluent in healthcare assurance issues. Because of the very pressing challenges for this trust, the board sub-committees need to be quickly brought up to a high-performing standard. (R5)

h) Under-emphasis of management

The clinical directorates do not have an authentic common structure, and in practice, managerial roles differ between them. The triumvirate leadership approach is understood largely as being by consensus and between equals with different jobs to carry out rather than teamwork under an identified leader who is accountable for performance, quality and resources. This is being addressed in the new divisional structure that is currently being instituted with the triumvirate in the new structure reporting to an accountable divisional director. The divisional directors will report to the COO for BSUH.

The new leadership has embarked on a strong change programme, but at the same time is keen to retain some structures to ensure that BSUH does not overwhelming feel the changes are being externally driven from Western. For this reason, the new divisional structures will retain the clinical directorates, although the new divisional management are expected to start to reform these into care groups that bring together specialities in a common-sense way. The new divisional structure is being put in place at the same time as the two trusts put in place local leadership for each trust that will report to the 'group' executive, with a COO in place at BSUH who will have a trust leadership team reporting to him. Line management will be emphasised, with the new divisional directors being pivotal to making this work.

3.2 At the same time, a strong theme to emerge from our interviews and observations is that a change in tempo and culture is already starting to germinate. Some long-standing issues have been addressed by this management that have been skipped by others. This has been very important and holds promise to move the trust's beliefs about itself on from normalising missing targets and putting up with the dysfunctional. In looking at the quality management and governance structure, we recommend that this is another candidate for instituting a new way of working rather than trying to amend the existing structure. (R6) The current 'family tree' of different governance groups is terminally confusing and poorly connected. The confusion of governance and management needs to be addressed (R7), and the opportunity afforded by the introduction of the new divisions should not be missed. Skills need developing at all level, and where the opportunity arises it is important to recruit in individuals with relevant experience.

4. Governance to deliver improvement at all levels

4.1 High-performing organisations use good governance to engineer change. This allows measured risk taking, provides management with a frame of reference around the agreed risk appetite within which to deliver change and ensures that assurance adds value rather than just satisfies regulators.

4.2 Because this organisation is challenged, no lesser standard of good governance should be expected. Governance systems need to deliver solutions to the trust's problems, but at the moment they are one of the very real problems that will frustrate the board's ability to preside over transformation and achieve success.

4.3 We have already mentioned that any governance solution needs to be scalable. (R8) For the period of the management contract at least, the trust finds itself in what is effectively a group arrangement. This all the more emphasises the need for developing strong local accountability at divisional level, with highly-effective assurance processes that deliver authentic board to ward insight.

4.4 We address our findings and recommendations at three levels:

A. The board

We have not made this the main focus of our attention as the board has radically changed over the last seven months, with an entirely new executive team and a palpable change of tempo described to us as a result of this. The new non-executives and associate non-executives are having an impact too. We are, however, making recommendations that will affect the committee structure, the board assurance framework and the board's cycle of business. Because this is such a stressed trust, we are also making recommendations around individual and group capacity and capability within the board.

B. The local team (central) clinical governance structure and resource

There has been some good work done on individual aspects of clinical governance, but this is the opportunity to design and implement a lean, focused and easily-understandable clinical governance structure. The trust will need to develop an appropriate central resource that at the same time can foster capacity building within the new divisions and take a whole-organisation view around clinical governance. This will ensure the executive is able to better manage the organisation and the ensure the board is well-sighted and assured.

C. The new divisions

The performance issues of the trust will be best addressed through able and agile management at the divisional level. The new divisions have the opportunity to step-up their management focus at the same time as the new clinical governance structure comes into place, and if this is done in a systematic way and with pace the trust has the opportunity to have the earned responsibility described earlier prior to the next expected CQC visit. We understand that this will be around April 2018 or shortly afterwards.

A. The board

The starting point for good governance is to understand that the board is the controlling mind of the organisation. Organisations are run by people, and those who direct an organisation and act as the organisation's controlling mind need to be readily identifiable. This enables all stakeholders and interested parties to understand who is accountable for the control of the organisation and who can enter into engagements on the organisation's behalf. Directors have responsibilities in law for looking after the interests of the organisation and all stakeholders. How this is executed will change as the organisation encounters different opportunities and challenges. Good governance means directors acting collectively in what is usually termed as a board, the overall accountable group that comprises the controlling mind.

All legal entities should be controlled by identifiable individuals who can be brought to account for their actions. They should be competent to fulfil this role and possess the required skills and experience. Within an organisation, it is important to be able to distinguish between those who are accountable for the organisation and those who are not. This is important for both internal control, and to ensure that external parties understand with whom they can make binding arrangements on behalf of the organisation. Those controlling an organisation need to be formally required to look after all stakeholder interests. They should have formal duties around their conduct and accountability. In an organisation as complex as an NHS acute trust under special measures, directors should have ongoing support through appraisal and development programmes to enable them to discharge their responsibilities.

Governing boards need to formally agree in an open and transparent way what role they will take in the detailed direction of an organisation. This will be different for each organisation, and will be dependent on levels of risk, market forces, the detailed knowledge required to undertake particular tasks, and the maturity of management. (R9)

Boards will set out how they govern through a system of delegation and reservation (R10). The board will decide what decisions it reserves (or holds) to itself as a governance responsibility, and those it will delegate elsewhere. The most significant delegation is usually to the accountable officer, the executive directors and senior management. Boards may also delegate to sub-groups, advisors and partners or through other controlled means. Boards will describe the limits and substance of all delegations and reservations in formal terms. As the controlling mind of the organisation, the board needs to plan and be explicit about the level of direction it will need to exert itself, and that which it is comfortable to discharge to others, both within and outside the organisation. This will help other stakeholders assess risks and the standard of controls for themselves.

Typical forms of delegation within an organisation, aside that to management, will include formally agreed delegation to board sub-committees. These should be few in number and not confused with management groups which are often, misleadingly, also termed committees (R11). Ideally the programme of work for committees should be linked to the BAF, with the board commissioning the assurance functions of sub-committees and linking this to the strategic aims of the organisation. In BSUH and as noted later, there is an unhelpful tendency for management groups to be referred to as committees and even boards, and the current structure describes these management groups as directly reporting through board sub-committees.

The only required board sub-committees are audit, and remuneration and appointments. Many organisations will have a charitable funds committee. NHS boards also have a statutory duty of quality, so universally establish a quality committee. In this report we just focus on the quality and audit committees (R30), recognising that the trust board has other sub-committees including a finance and investment committee (R12) and a 3Ts board. Currently, the governance arrangements around the 3Ts board is being reviewed by trust management (R13).

Sub-committees are almost always chaired by directors, and most commonly by non-executive directors. Whatever the chairing arrangements, it is important that the chair has sufficient technical knowledge to be able to take the committee through the issues concerned and to pick out the key assurance points as they arise and ensure that the committee scrutinises these. Directors have legal requirements to understand the business in hand, the market they operate in and the regulatory framework within which they operate.

The distinction between governance and management is important to emphasise. Boards govern, and delegate the operation of the entity for which they are responsible to management. Therefore, governance concerns:

- *Vision* – being certain why the organisation exists in the first place, its purpose and what difference it intends to make
- *Strategy* – the planned means by which the organisation delivers the vision
- *Leadership* – how the organisation is able to deliver the strategy over time
- *Assurance* – that the organisation does what it says it will do and behaves in the manner it has agreed
- *Probity*[7] – that the organisation meets standards of openness and transparency, acts with integrity and in good faith. In the public sector, taking note of the Nolan principles of public life
- *Stewardship* – that the organisation is responsible with resources, especially other people's resources (such as credit or in the NHS, often research funding)

The purpose of governance is to ensure better decisions. We separate governance from management by the role each has in decisions. Management makes (or crafts) decisions. By this we mean management identifies an issue, gathers and analyses the data, identifies and weighs options, consults, and comes up with recommendations. Directors in their governance role then take decisions, and move at that point from being responsible to accountable. Management runs the organisation month on month, being mandated by the board to exert operational control and direction against an agreed strategy and policies.

Boards add value by the very fact that they are not directly controlling the entity operationally. Through an agreed assurance system, the board holds the management to account for delivering the strategy and meeting requirements (such as contractual obligations or legal compliances) of the organisation. In order to do this, management and governance roles need carefully separating out, but relating to each other. This is a critically important point to appreciate when it comes to the roles of committees and groups within an organisation. Board sub-committees must not become muddled up with the operational management of the organisation, and must not find themselves in a position where they end up, de facto, managing functions or creating assurances. The board must be clear about what authority it delegates to committees. A clear distinction must be made between board committees and management functions and groups.

The board, through its sub-committees, needs to be assured that management is operating within whatever delegations the board has made and is operating agreed controls to mitigate or avoid risks. In terms of groups, we would explain the difference between a board sub-committee and a management group as follows:

- **Board sub-committee:** the board of directors will delegate a number of its functions to committees, who are responsible for reporting to the board on the critical areas of business (for example, compliance, quality etc.) and for escalating risks as appropriate. Unlike management groups, board sub-committees are not responsible for the day-top-day running of the organisation but rather seek assurance that performance and systems are operating to the required standards
- **Management group:** management groups are accountable for the day-to-day, month on month running of the trust and for providing assurance to management, who in turn assure the board (often through sub-committees) that performance and systems are at the required standards

Good governance practice includes the programme of work for sub-committees of the board being linked to the BAF, with the board commissioning the assurance function of the sub-committees and linking this to the strategic aims of the organisation (R14). At the same time, a quality management system within management will itself be ensuring that the controls against risks identified in the assurance framework are being applied, and so will continually be providing management with detail and assurance (R15). It is important to recognise that a key element of good quality management will be quality assurance, and the board's role, delivered usually through the sub-committees' work programme, will be to be assured that the quality management system is operating reliably and effectively.

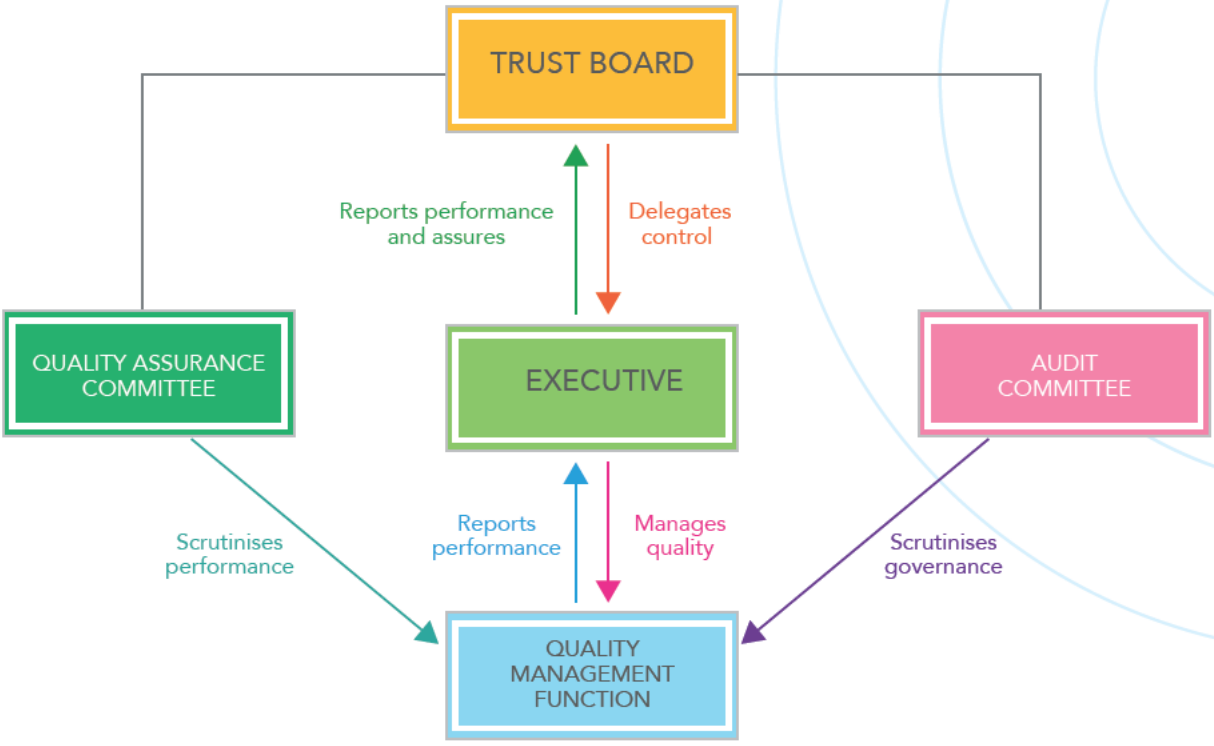
7) Committee on Standards in Public Life; 'The seven principles of public life'; HM Government, London; May 1995

We would add a word about the difference in focus between quality assurance and quality improvement which we have eluded to earlier. These are very different, but related, activities. Successful trusts disaggregate the two as their processes are very different. Quality assurance concerns the disciplining of work to meet designed standards. Management need assurance that work undertaken is complying with the set standards. Quality improvement is about redesigning work, often radically, to create a shift in performance by changing the rules. It can be a centrally supported activity, but by its nature needs to be a locally delivered one as the literature shows that those with the best insight into redesigning work are the operational teams themselves.

We have worked with very challenged trusts that have come out of special measures and that have, as a key building block for their success, carefully distinguished between assurance and improvement work and created proper forums for each. For example, and around serious incidents (Sis), one forum needs to be in place to support the proper conduct of investigation and the root cause analysis process, but the learning and sharing of lessons is best done otherwise and probably using different meeting techniques. To conflate the two together into an assurance committee format stultifies the learning and improvement environment.

The quality committee and the audit committee need to work in parallel, as the audit committee has an accountability to assure the board around the full breadth of the functioning of governance systems and assurance processes (R16). The quality committee can triangulate and scrutinise matters around content, with the audit committee focussing on joined up process. Again, the focus of attention is the quality management system as it is operated by management rather than to attempt to operate the management system itself. Figure 1 below describes a classic board assurance structure around assurance of a functioning quality management system.

Figure 1 - Board assurance of quality management through board sub-committees



In terms of governance impact, this board is in its early days. We do recognise that this is not a new organisation and in the past five years many board members on both the executive and non-executive sides have done much to attempt to create a well-performing board. We are of the view that in real terms, because of the scale of change and the management contract arrangement with Western, it is best for the board to think of itself as a new board needing to operate at a different level to the prior board. From our interviews we believe that this will require a change in thinking for some who were on the journey prior to the new management contract. We would like to see that experience and history-holding made useful to the board as it currently is.

A common theme expressed to us by non-executives was that whilst they now feel 'less connected' than previously, they feel 'more assured' by the new leadership in place. Regular open and transparent communication was regarded as being important by the non-executives moving forward in order to promote unified working with the executive team.

The group-type structure, covering two linked but discrete entities, is new for the NHS. There are models from different parts of the country, and each has its own distinctive features. The important realisation needs to be, though, that the way in which a board within such a group operates requires commensurate new ways of working and skills from board members. An independent appraisal of director skills would be helpful to ensure that, in the first year, the board is operating at the required level and that directors have the skills and capabilities to deliver the new task. As we have previously stated, we were not at this stage asked to test individual director capability and capacity and align this to the current board's needs, but we do think that to minimise risk the board needs to be populated with experienced and high-calibre directors and we cannot immediately see this across the entire non-executive team.

Figure 2 below describes the maturity levels within an NHS trust board (as a body, rather than as individuals). We have not formally evaluated this trust board as it is early days but given this we could not see any area where the board was operating above level 2 (basic level agreement of commitment and direction). Once the strategy has been agreed and new roles and responsibilities are instituted the board really should be at least level 3 (early progress in development) by March 2018, but we believe with focus the board could have in some areas achieved level 4 (firm progress in development) by that time (R17).

NHS BOARD GOOD GOVERNANCE MATURITY MATRIX: BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST, DEVELOPMENT EXPECTATIONS FOR THE BOARD BY MARCH 2018

VERSION 1.0 DECEMBER 2015

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
PURPOSE AND VISION	No	Purpose, values, and drivers debated and priorities being formulated. The board is involved in shaping these discussions demonstrating quality as fundamental driver.	Purpose & vision agreed, and affirmed in public and internal / partnership documents. Board has an agreed set of values / principles.	National targets and local priorities agreed with stakeholders. Variance from HWB & commissioners plans / priorities recognised and explained.	Board has a robust inclusive mechanism for adding and removing services and / or changing care settings that matches agreed purpose, values and priorities.	Evidence that sustained progress towards the vision is being made. Purpose and vision are systematically revisited as board membership changes or at least annually.	Partner organisations and internal stakeholders understand and support the purpose and vision of the organisation. Strategic decisions do not change fundamentals.	Success has allowed trust / board to redefine / extend its role. Ongoing influence of other organisations to meet own and wider stakeholders purpose.
STRATEGY AND BOARD ASSURANCE FRAMEWORK (BAF)	No	Strategic objectives agreed by board and tested with partners. Formal strategic planning in place able to address HWB & CCG priorities.	Strategy owned and agreed by board, after canvassing views and input from commissioners, partners and other stakeholders.	BAF used as key instrument to grasp strategic focus. Operational plans reflect trajectory milestones against agreed strategy.	Progress against delivery made during year. Board has protected long-term priorities from short-term pressures.	Board continually testing how changing environment effects delivery of strategy. First goals being met.	Evidence that strategic aims are being adhered to, meeting agreed milestones on trajectory.	Trust/board is able to demonstrate consistent achievement of strategic goals over the last 3 years.
LEADERSHIP AND CAPACITY	No	Clarity of roles of all board members with specific job descriptions agreed.	Skills assessment of board linked to succession plan. Planned board development programme.	Board development programme is based on prior systematic review. Clinical leadership accepts accountability for delivery against strategic objectives. Assessment & PDPs in place for board members.	Succession plan in place. Individual PDPs for directors being delivered.	Board is confident it is visible. Leading rather than following local development agenda.	Organisation is identified as well led throughout organisation and as health & wellbeing system leader in local economy.	Board considered a national leader, providing buddying support and example to provider chains & other organisations.
MONEY/VFM	No	Budget, cost pressures & efficiency targets are clearly identified to board.	All in-year plans are costed and trajectory of spend / savings established to achieve breakeven / target. Quality implications robustly tested.	Record of meeting planned cost reductions / CIPs and agreed investments, whilst rejecting proposals with an unacceptable impact on quality.	Board is demonstrably reinvesting whole budget. Rather than being limited by 'affordability' at margins.	Unexpected in year pressures are identified and board show timely reprioritisation of deliverables.	Services consistently running under benchmark cost. Headroom created for developments / improvement.	Successful leverage of wider community resources to improve service delivery and outcomes.
QUALITY, RISK AND AGILITY	No	Known risks identified and continuity plans in place. Board understands risk at a comprehensive strategic instrument.	Forward-looking risk system in place for board identifying both threats and opportunities . Quality impact embedded in systems.	Risk appetite for key issues such as safe staffing levels known and built into plans/BAF.	Continuity plans and 'what if?' scenarios are regularly tested to respond to material issues and opportunities.	Board confident it can both anticipate and respond to a crisis/opportunity in timely fashion. Can quote case studies of successful escalation and intervention.	Board is able to measure and demonstrate risk appreciation by avoiding or agile response to predictable incidents.	Board has successful, demonstrable risk mitigation track record. Systems respond well to unknowns as they occur.

Minimum level required to be achieved by March 2018

Figure 2 - NHS board good governance maturity matrix: Brighton and Sussex University Hospitals NHS Trust

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
MEASUREMENT AND INTEGRATED REPORTING	No	Board has understood and recognised value of quality assured processed data. Board reports are accurate and timely.	Resources are aligned to sustainable targets, standards and local priorities. All board papers integrate activity, cost, quality & transformation agendas. BAF and reporting relate.	Board has agreed public reporting for social, economic and environmental impact / opportunities (integrated reporting).	Health improvement / harm reduction targets agreed. Systematic outcome-related reporting to board and stakeholders. Board confident it understands how it deploys its capitals.	Annual review of board demonstrates candid self awareness and progress against agreed action plans / deliverables.	Board systematically receives reports from stakeholders providing feedback of impact of plan implementation.	Organisation benchmarks as a national leader in terms of positive impact on local health economy.
ASSURANCE AND STEWARDSHIP	No	Integrated audit committee in place, with annual cycle of business. Board assures itself that Assurance Framework is balanced & can reflect changing priorities.	Control mechanisms in place for entire BAF. Board has identified, agreed & owns assurances. Annual review audit committee, and of committee cycles of business agreed by board.	Independent assurance systematically sought through internal and clinical audit. All regulatory compliances, tests and actions met or explained.	Board annually delegates / confirms tolerance levels for assurance to sub-committees. Board can demonstrate robust scrutiny.	Organisation able to invest significant resources derived from own savings / service change to community wellbeing, research, innovation & staff development.	Board confident it has evidence based, intelligent analysis & assurance of all systems and drivers across the health economy.	Organisation benchmarks as a national leader in terms of sustainable outcomes and impact against resources.
PROBITY AND REPUTATION	No	Standards of Conduct for board explicit and accepted. Plans in place to manage conflicts of interest.	Conflicts of interest system includes board and senior staff, is up-to-date and records actions.	Board has third party evidence of its reputation and standing. Risk appetite thinking includes reputation.	Probity expected of all partners, suppliers and providers and this is written into contracts.	Reputational risk considered in scenario and 'what if?' exercises. Reputational risk appetite agreed.	Organisation seeks and acquires good governance recognition by independent authority.	Organisation able to show how high-standing benefits achievement of strategy including recruitment and partnership working.
DECISION-MAKING AND DECISION-TAKING	No	Decision-making includes appropriate consultation and option/impact appraisal.	Information processing and analysis focussed on evidence. Board and committee agendas reflect materiality.	Integrated information, audit, assurance and risk-assessments used by board.	Board consistently takes decisions based on materiality and evidence.	Evidence that board and staff confident that the board takes decisions in a robust, transparent manner, assurances available to stakeholders.	Audit committee has reviewed key decisions of board and delegated committees for robustness and alignment.	Board able successfully to influence national decision taking on policy and priorities.
STAKEHOLDER ENGAGEMENT	No	Engagement policy and strategy in place based on stakeholder mapping.	Service user, staff, public and partner engagement recognised as resource to focus, design and deliver service improvement.	Membership targets met and board of governors / users panel in place with own development plans.	Stakeholders confirm organisation effectively engages with them and this is reflected in strategies and plans. Governors' contribution valued.	Governance between organisations issues regularly tested with partners.	Partners, service users and the local public trust organisation. Seen as employer of choice.	Organisation recognised as a national leader in effective engagement with stakeholders.
BOARD SUPPORTS AND COMMITTEE STRUCTURES	No	Audit committee role developed to take on independent scrutiny function. Committee structure confirmed by last annual board review.	Board Sec or other holds compliance and tracking role for all assurance issues of the board. SID appointed.	Workload and agendas for committees planned and task groups have time-limited existence.	Audit committee meeting at least 'firm progress' levels of audit committee matrix. Internal & external auditors & advisors aligned to agenda & role.	Annual cycle of board business reviewed at year-end, planned activities completed and developed roles refreshed.	Overall time investment in board and committees reduced through organisation effectiveness.	Board's systems adopted by others as examples of good governance practice.
APPRAISAL PROCESS OF DIRECTORS, AND OTHER FEEDBACK	No	Clarity of role for all board members understood and explicit.	Board induction & development process in place and working. Annual board review conducted and actioned.	Third party views included in annual board review process. Chair reviews board contribution of all executives.	Annual review and director appraisal has informed current board development programme which is clearly actioned.	Systematic feedback sought on added value of board. Exit interviews always offered.	Board is recognised as adding value by CEO and stakeholders.	Board recognised 'as public appointment of choice' nationally.

Minimum level required to be achieved by March 2018

B. The local team (central) clinical governance structure and resource

The trust had historically put an emphasis on developing a strong central clinical governance resource, with expertise built up and residing in key team members. This approach has its potential merits, such as the ability to develop skills and consistency of approach, and to have the ability of looking for trends across the whole organisation. However, despite best efforts the former regime did not manage the scale of engagement needed to bring the teams delivering services with them. Neither did the aspiration of joining up quality themes between the different quality activities, such as audit and incident reporting, lead to a reliable quality assurance system nor an understandable programme of quality improvement. Staff could not convincingly explain to the CQC how the quality system of the trust operated and neither were they able to show a track record of action plans being implemented (R18).

We have developed the following matrix for BSUH to describe the central clinical governance capacity and capability. We have scored the trust based on our work with you. In parallel with the implementation of the new divisional structure, we believe that the trust could achieve level 3 'early progress' with some elements achieving level 4 'firm progress' by March 2018 (R19). This would provide a good platform for the up and coming CQC visit.

Good Governance Institute

CLINICAL GOVERNANCE
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS TRUST
A MATURITY MATRIX TO SUPPORT THE DEVELOPMENT AND IMPROVEMENT OF CLINICAL GOVERNANCE

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 7

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS	5 MATURITY	6 EXEMPLAR
LEADERSHIP AND STRATEGIC DIRECTION	No	The trust board has agreed a commitment to the delivery of safe, high quality and harm free care. The governance structure clarifies leadership responsibilities for the management of risk, quality and safety.	The board has debated its appetite for risk in the context of risks to the quality and safety of services. Decision-making is informed by these discussions. The board has defined its Quality and Safety Strategy plans and time limited outcomes.	There is a clear plan for leadership support and development, supported by training and development plans and succession planning.	The organisation is able to evidence how it consistently and effectively supports the development of its clinical leadership teams.	The trust is achieving its strategic objectives, and has reviewed and tested and adjusted its strategic direction in the light of changing circumstances.	The trust influences national and international practice, and is recognised for publishing and sharing examples of best practice.
RISK MANAGEMENT AND ASSURANCE SYSTEMS	No	The trust has set out its commitment to the management of all risks to clinical quality and safety. A clear system for risk assessment and escalation is in place. There are metrics in place designed to provide assurance on compliance with national guidelines, and applicable guidance, standards and targets. There is a board sub-committee charged with securing assurance on clinical quality and safety.	Risk systems are aligned to board priorities and expectations of clinical effectiveness. There is a described and communicated system from front line to the board, which allows for the identification of risks to clinical and care quality, the monitoring of risk management actions and the escalation of issues that cannot be managed locally.	Challenge on clinical issues debated at the assurance committee and board is informed and constructive. Potential internal and external system failures affecting clinical quality and safety are identified in risk registers and mitigated appropriately.	Issues are systematically identified and addressed without regulatory input. There are no surprises or resistance when data is requested, inspected or challenged. The risk management system, including effectiveness of related committees and groups, is monitored and any identified adjustments are implemented.	National clinical standards and targets are consistently achieved. Divisional systems for tracking compliance and monitoring action plans are in place and functioning. Information emerging through the risk system triangulates with other data from governance reporting.	The organisation provides benchmark data externally and welcomes comparison and inspection. Other organisations visit the trust to learn about our best practice approaches.
PATIENT SAFETY	No	There is a trust-wide commitment to patient safety, characterised by the existence of clear roles and responsibilities at both corporate and divisional levels. There is a trust-wide incident and investigation policy and procedure and governance forums at all levels discuss reported incidents and risks. This includes the means of sharing learning from incidents across the trust. There is a clear and communicated procedure for Disclosure (whistleblowing), and for the Duty of Candour.	Maintaining and improving safety is a key priority for divisional leaders and staff. Incident reporting levels increase. Clinical safety targets are set out for all divisions. The investigation process is in place and staff are trained to support it.	Results of incident reporting and recommendations from investigations are debated at board or board sub-committee level. More moderate and low harm incidents are observed with fewer serious level incidents. Ownership of investigation and learning is evidenced at divisional and local levels. There is testing of the reporting culture and the understanding of Duty of Candour processes. Compliance issues are identified and escalated according to risk or incident grading.	Reporting rates are in the upper quartile (NRLS). There is a reduction on numbers of breaches of outstanding Serious Incident closure. All response deadlines show improvement.	There is a routine report of evidence of the effectiveness of activity to mitigate risk and to learn from incidents and other governance information. Patients and families are involved in safety initiatives. Fewer compliance issues emerge from risk and incident reporting.	The trust demonstrates sustained evidence of improvement in safety priorities and targets.

Minimum level required to be achieved by March 2018

Figure 3 - Clinical governance at BSUH

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS	5 MATURITY	6 EXEMPLAR
CLINICAL EFFECTIVENESS	No	Key elements of clinical effectiveness are identified including safety, effectiveness, clinical audit and patient experience. There is a trust audit plan which reflects national as well as local priorities.	e board has clarity on how it is assured of clinical effectiveness from across the trust, evidenced by divisional and specialty plans.	Divisions and specialties include discussion, analysis and sharing of effectiveness in their governance structures and processes.	Performance against clinical standards is recorded, reviewed and improving, including achieving results and / or evidences of changed practice in identified focus areas. There are mechanisms go allow sharing of effectiveness information between divisions and specialties.	The trust consistently performs highly against clinical standards. Innovative approaches have been assessed for effectiveness and sustainability and are being mainstreamed in service delivery. The organisation can demonstrate that it learns from the t iangulation of clinical audit findings with other quality measures within and between services.	The trust can demonstrate an evidence base of achieving sustained results in clinical effectiveness, and is recognised as a source of sustained best practice.
PATIENT EXPERIENCE	No	The trust understands the importance of involving patients, carers and families in governance and decision-making processes and service development plans, and this has been promoted in documentation. There is a senior level group responsible for reviewing practice and performance on complaints management and learning, feedback mechanisms, FFT, engagement and involvement, across the trust and reporting to board level.	The board has involved patients, carers and stakeholders in developing its Quality and Safety Strategy plans and time limited outcomes. There is a patient and public involvement plan in place that goes beyond board representation.	Mechanisms are in place to ensure that patient feedback is routinely collected. Patients and carers are engaged and feel confident providing their feedback to the organisation. The board has defined its patient and public involvement strategy, plans, and time-limited outcomes.	Patient experience and complaints targets are being met. Patients report confidence in the responsiveness and effectiveness of the service experienced. Performance against service user involvement standards and outcomes is recorded and improving.	Development and improvement programmes routinely engage patients and this is demonstrably driving improvement across the trust. There is a trust wide programme to support and develop patient leadership. The organisation can demonstrate that it learns from the triangulation of patient experience data with other quality measures and across services.	Lessons on engagement and improvement are shared beyond the organisation.
STAFF ENGAGEMENT	No	The trust understands and values expertise of all its staff and their importance in decision-making processes. This has been promoted in documentation. Staff are able to articulate the purpose and values of the organisation.	The board has involved staff in developing its clinical improvement strategy, plans and time limited outcomes. Staff are clear on their roles and responsibilities with regard to clinical governance and achieving improved outcomes.	Staff are empowered to identify and make improvements. The organisation is open and responsive to staff concerns, contributions and feedback. Reward and celebration are built into the staff engagement approach.	Evidence from staff surveys demonstrates that staff feel involved in, and take ownership of clinical governance. Appropriate forums exist for staff to learn from quality improvement initiatives, and for staff to receive structured feedback.	Progress has been made in those areas identified as needing improvement from staff surveys and other engagement mechanisms. Staff report confidence in the effectiveness of the organisation to receive constructive scrutiny, deliver improvement, and staff's ability to affect these processes. Staff feel acknowledged and rewarded for their contributions.	The trust is regarded as a centre of best practice for staff involvement and engagement in service improvement. Staff survey results show year on year improvement.
USE OF INFORMATION: REPORTING AND MONITORING	No	The reporting routes across the trust are clearly set out and supported by information systems. Staff understand their role in managing and maintaining data quality in information systems.	Staff (and board members) at all levels are empowered through training to properly understand and utilise, interrogate and challenge data appearing in dashboards and reports. Data is accessible and transparent.	Systems are aligned and allow for the easy sharing of information and data. Outcome data is routinely used to guide operational decision-making processes. Risks and movements in performance are evident and understood by the board, and used to drive improvement.	The board has confidence in the quality of its data, and is able to present one version of the truth externally.	The organisation is able to utilise its reporting to escalate and address issues at an early stage and consistently uses data to drive improvement. The organisation has appropriate, and well attended, forums for staff to share and learn from previous work and incidents encountered.	Data collected drives improvement across all areas of the organisation. Lessons learned and best practice are benchmarked and shared externally.

Minimum level required to be achieved by March 2018

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS	5 MATURITY	6 EXEMPLAR
ENABLING LEARNING AND SHARING: THE RELATIONSHIP BETWEEN CORPORATE BODY AND DIVISIONS	No	The trust board has set out their expectations of all departments and divisions, with regard to quality and safety, and clarified tolerances for escalation. The information flows between specialities, directorates and divisions are described.	Divisions have identified plans in line with the trust's strategic direction and have described their reporting processes upwards. Clinical leaders have mechanisms for liaising and sharing learning with colleagues across Divisions as well as between Divisions and trust leadership.	There is a central system for monitoring outstanding actions or exceptions from all reported action plans, and follow up with divisions. The escalation system is reviewed and tested at intervals.	There are working mechanisms for supporting divisions and front line staff in managing risk and issues locally. There is routine good attendance at clinical governance meetings at all levels, with all Divisions being well represented at trust wide and senior meetings.	Performance is consistently improving across services. Strategic objectives are on track. A consistently good level of recruitment to clinical positions is sustained. Staff surveys indicate good visibility of the senior team and consistent good attendance at routine and ad hoc communications and briefings sessions.	The trust is regarded as an exemplar in internal communications and in clinical service provision. Other trusts and clinical bodies or organisations visit to observe best practice.

Minimum level required to be achieved by March 2018

Our review's findings for each of the key elements is as follows:

i) Leadership and strategic direction

The current board clearly sees safety and quality as key priorities and board and committee agendas reflect this commitment. Challenge is constructive and patient-care focussed. A key challenge for quality and safety at the trust will be to create a workable balance between central control and devolved responsibility. The central role will itself be a balance of direction, support, information provision, guidance and monitoring. It is important that the new divisions are seen as customers of the central functions to pitch this role in the right way.

As we have noted, there has been much upheaval and inconsistency in senior leadership of recent years, and value is should be attached to organisational memory where it exists. The loyalty and skills of several members of staff involved in safety and governance in particular commendable. It is also important to note that some previous structures observed and described in related documentation have been logical and based on best practice. They appear to have failed, however, due to the inability to support, resource or lead them effectively.

Leadership for governance is currently shared between the Chief Nurse (incident reporting, patient experience, safeguarding, Infection Prevention and Control) and the Medical Director (clinical outcomes, quality improvement, appraisal and revalidation and Caldicott issues). There is no Director or Head of Corporate or Clinical Governance at present. Two Associate Medical Directors have taken on safety and revalidation roles respectively. The Head of Patient Safety provides a cohesive and responsive service for safety and effectiveness but is reporting to different people for different activities. Patient experience is managed separately. The responsibilities and reporting routes for risk management were unclear at the time of the review.

There is an acknowledged need to rationalise groups and sub-groups (or 'feeder' groups) and ensure that governance structures incorporate both key functions and also make strong links across divisions, specialities and the centre (R20). It is critical that the revised structure sets out decision-making responsibility at all levels. We recommend a new structure later.

There is confusion as to whether some key groups feed into the Patient Safety Committee (PSC) or the Quality and Risk Committee, or indeed other groups in the trust structure. Our view is that this is academic, as we have suggested a new structure to reflect Lord Darzi's dimensions for quality plus one group to focus on risk and compliance.

The review team noted in particular that the current monthly Nursing and Midwifery Board is well attended and valued but does not report into anywhere. Underlying this confusion is an unhelpful tendency to name many groups as "committees" where they are not sub-committees of the board. There is also need to clarify and communicate decisions on the wider issue of the nature of assurance committees in relation to executive or decision-making groups. There is an urgent need to create a wider executive clinical governance and quality and safety group, into which the (current named) Patient Safety Committee, Clinical Effectiveness and Patient Experience groups report (i.e the "Darzi" dimensions of quality).

While the imperatives in clinical governance seem to be clearly understood by the senior team, the key question of where and how the key elements of quality are managed remains to be clarified. Responsibilities for quality, risk and safety can then be set out and defined for each level of the organisation, with associated leadership development plans for clinical leaders.

Leadership for quality improvement must develop a plan to go beyond the CQC response and ensure that the trust is equipped to identify objectives, and an associated framework which actively supports and engages clinical and other teams in activity aligned to trust objectives and aspirations.

ii) Risk management and assurance systems

The Chief Nurse is currently overseeing risk, following the departure of the Director of Corporate Governance. The Corporate Risk Register (CRR) observed was from April 2017 and the BAF from February 2017 (R21). Both these documents appeared to be well constructed with clear formats. Neither showed many quantifiable measures of success or movement. The BAF was linked to three strategic objectives and contained a great deal of commentary on the 21 overlapping high level issues identified. It is likely that the new board is constructing these supporting risk management tools in a different way.

Reportedly, the Risk Management Committee still meets and reports into the QRC. No recent minutes were observed during the review and the role and reporting routes for this group must be prioritised.

The Risk Management Strategy from September 2016 sets out a clear policy, reporting and escalation process, roles and responsibilities for groups and individuals. It is particularly and commendably clear on review of the BAF and CRR. For reasons stated in the previous section, this has not been fully implemented and risk management at directorate level is likely to be patchy as a result. There is a feeling that risk management is a central function and ownership at local level is reportedly low. While staff may be clear on their responsibility to raise concerns, risk and issues, it appears unlikely that they are consistently well-motivated or empowered to use the available formal escalation routes (R22).

iii) Patient safety

There is a clear process for incident reporting and investigation and this is acknowledged to be managed well, particularly in respect of investigation and the quality of reports. The culture of reporting is a concern, with under reporting of moderate incidents evident, and there is scope to drive a stronger understanding of patient safety generally using the new divisional structure. There are normative expectations about reporting levels, and normative relationships between SIs, incidents that cause harm, incidents that do not cause harm, reported near-misses and unsafe practice. The trust should be continually comparing itself to these to understand how well the incident reporting system is working, and whether a reporting culture is being gradually developed (R23).

The Patient Safety Committee is poorly attended but has a wide-ranging agenda. The structural changes suggested elsewhere should help to refocus this group and build on the good work in incident reporting and triangulation of learning. There is potential to develop two forums: one for review of process and one for learning and sharing. This approach has been developed elsewhere and proved a useful way for engaging local teams. It should be re-named the 'Patient safety group'.

Serious and moderate incidents are discussed at a weekly panel and routinely are all reported to the Chief Nurse and the Medical Director. They are also reviewed for their Duty of Candour implications. There is scope to move to a more learning-based approach where serious incidents are revisited to ensure that actions have had the desired outcomes for improvement.

Investigations are run from the central team, mainly by two investigators. The process has been informed by specialist human factors advice and is robust. However, the new divisional teams will need to be clearly tasked with involvement in the investigation process, especially at the stage where improvements are identified, in order to improve local ownership and learning (R24).

The current patient safety function provides a significant level of information and dashboard data for directorates. The degree to which this is utilised at directorate level is questionable.

iv) Clinical effectiveness

The Associate Medical Director for Safety leads clinical audit and effectiveness and ensures the audit schedule is supported and implemented. There does not seem to be a clear strategy for clinical effectiveness nor is it clear how all professionals are involved in audit, how it is aligned to trust objectives, nor which board sub-committee has an overall responsibility for receiving assurance on the effectiveness of the process. We would suggest that both the quality and the audit committees have different but related roles whereby they should be interested in the clinical audit programme (R25).

The Clinical Effectiveness Group has not yet met. The group which reviewed NICE and other guidelines has also not reported recently. It seems unlikely that clinicians are receiving dashboards on clinical outcomes although there is access via the HEADS system to mortality information and there is a trust Mortality Review Group which reviews data to identify avoidable deaths, spikes in elective deaths and outcomes monthly.

v) Patient experience

The trust board clearly values patient experience and maintains a focus on ensuring access to patient feedback and responsiveness to complaints. In time, the board will wish to ensure that a patient story or patient journey is presented at meetings.

Complaints and PALS are incorporated into the patient experience function. There is a panel at the Royal Sussex County Hospital and one at Princess Royal Hospital.

The annual report we reviewed was factual and clear, but we observed little evidence of exploring underlying issues or contributory factors, or triangulation of data with other sources of quality information. There was also little evidence of setting out objectives for patient involvement or engagement in governance processes (e.g. safety initiatives, investigations), although this may exist elsewhere (R26).

vi) Staff engagement

The senior team is clear about the considerable workforce challenges and is committed to addressing these at pace. There was some positive feedback during this review on the support and commitment shown by the senior team and the messages going out to front line staff. A commitment to reflection and conversations as a means of learning, improving and sharing was also clearly articulated.

Rapid work on developing a simple vision and values "sign up" for staff will be a priority. There is also a huge opportunity to involve staff in the development of local responses to strategic priorities and in improvements. Involvement and engagement should also be underpinned by systems for reward, recognition and celebration.

There is some organisational memory of initiatives that have been or are helpful in engaging staff in improvement (e.g. the current learning podcast and previous After Action Reviews). Weekly meetings to discuss themes are planned and should kick start triangulation of clinical governance data across the trust.

It will also be important to support middle management in particular during change and in tacking difficult workforce issues.

vii) Use of information: reporting and monitoring

The Patient First initiative appears to be driving reporting currently, but it is acknowledged that there is work to do to develop effective integrated reporting.

There is a wealth of monthly clinical governance information collated by the patient safety department and shared with directorates, but perhaps not the skills or resource to utilise this well. The Western reporting dashboard is different from the BSUH one and requires some data which is currently not available. There is a need to set out and prioritise the next steps in achieving a clearer reporting system, including:

- Integrating clinical governance information with the overall reporting structure
- Rationalising the number of reports and metrics currently in use
- A single reporting template for feeder groups into an executive clinical governance group
- A standardised report quality and safety report from divisions
- Standardised reporting requirements from specialties and directorates
- Ward and departmental dashboards
- Accessing comparative data for benchmarking

- Ensuring the cycle of business and meetings schedule is aligned with reporting
- Identifying the support and training required for the workforce and all stakeholders to access, utilise, interpret and challenge data appropriately

In terms of information technology support, it was unclear whether there is a recent IT strategy which is fit for purpose. A significant requirement of the strategy will be to ensure that it is aligned to clinical services. Building confidence amongst clinical staff in the quality of data is key. The adequacy of data systems supporting mortality review has been raised during this review, and should be prioritised to allow an agile response to apparent trends or spikes. There also appears to be a need to prioritise and target available analytical resources to those areas where the need is greatest; for example, compliance with reporting on cancer pathways.

The presentation of information, report and meetings papers was generally found to be of high quality, with clear report summaries and good agenda and minute-taking practice.

viii) Enabling learning – relationship between corporate body and divisions

The creation of five divisions, each with a Chief of Service, presents an opportunity to improve the engagement of clinical leaders with trust leadership – for example at the trust executive committee (TEC). It will also ensure that governance at divisional level has a shared framework for meetings, reporting and learning. The priority for leaders across the trust will then be to support this framework and ensure routine monitoring as well as support and guidance.

There is not yet a clear understanding of how individual directorates are managing their governance responsibilities, nor whether these are clearly articulated as yet. Performance reviews are used to review directorate quality and safety information, but this process is not embedded.

There is some evidence of protected time for clinical governance and learning in the divisions (notably in the perioperative directorate at RSCH) but this is in constant conflict with the enormous pressure to focus on patient flow and productivity.

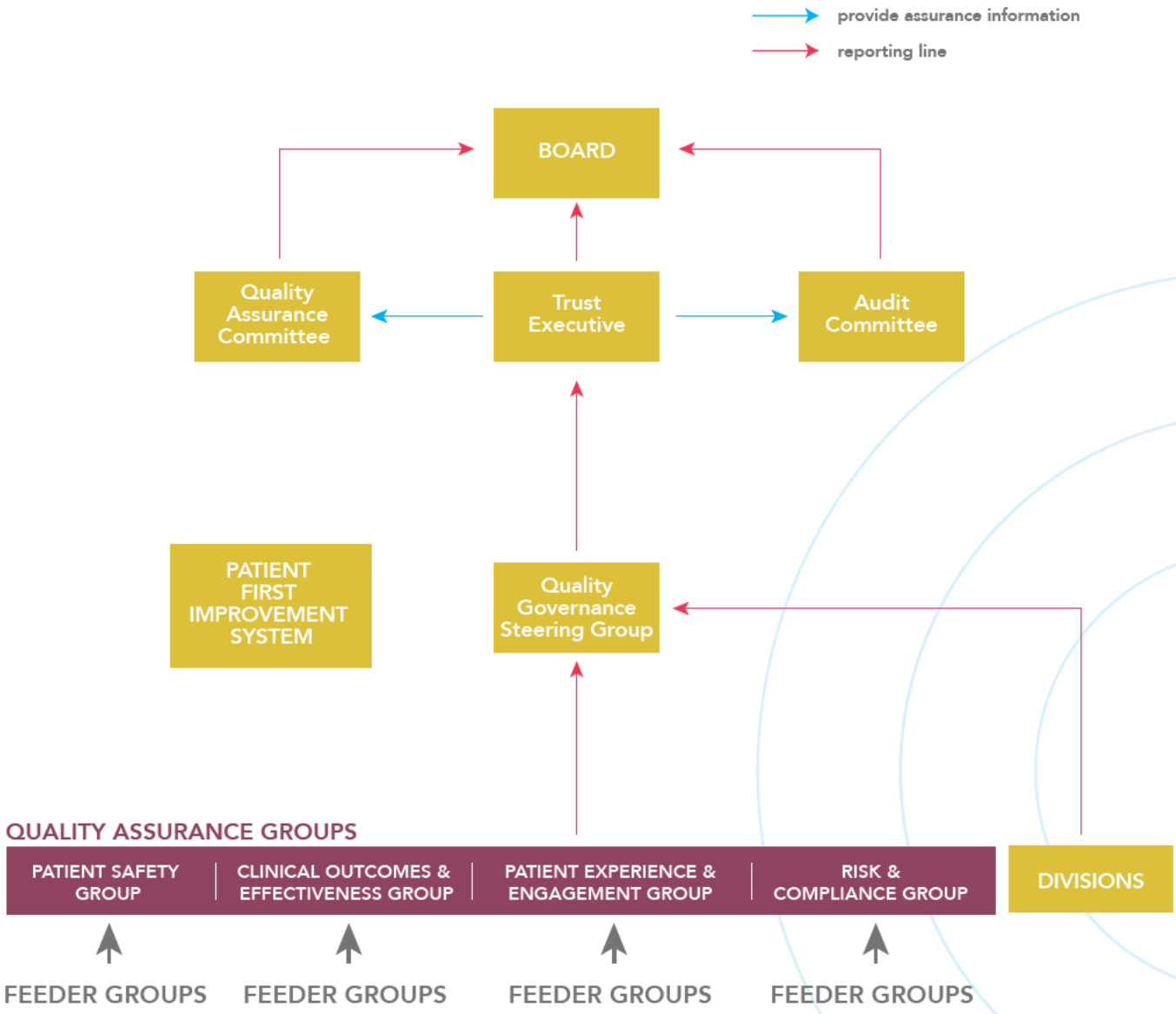
Priorities in setting up local governance structures will include:

- Developing local governance priorities in line with the trust strategy
- Mechanisms for cross-divisional learning
- Tracking of action as a result of incidents and other quality and safety activity
- Evaluating engagement in governance processes e.g. outcomes, staff surveys, attendance at meetings etc

ix) Quality management structure

We are have noted the structuring of quality management and recommend considerable simplification to this. Structurally, management need a focused forum to understand and scrutinise quality assurance and compliance data so that they can act on it, and in turn report assurance through to the board and sub-committees. A classic simplified structure for this is described below in Figure 4.

Figure 4 - Quality governance management groups structure



In this structure, the trust executive have within the quality management structure a whole-trust group that is able to take assurance from, and 'commission', more detailed work from a limited number of standing groups. The quality groups in this structure represent the three elements of quality as described by Lord Darzi, together with a related group to provide management oversight of the risk and compliance issues.

There are a plethora of groups with various quality responsibilities. We have attempted to catalogue these but can find no single version of the truth. We recommend that with immediate effect the trust institutes a new quality governance steering group which looks at quality issues across the trust and is used as the forum into which each of the divisional governance groups reports. These new four quality assurance groups will be able to take on a more focused and detailed assurance role for the main dimensions of quality, as described below.

Quality assurance groups

The three dimensions of quality care (as defined by Lord Darzi[8] and adopted by NHSE) are:

a) Care that is **clinically effective**, not just in the eyes of clinicians but in the eyes of patients themselves
b) Care that is **safe**
c) Care that provides as positive an **experience** for patients as possible.

With regard to quality of care governance, the trust must have robust structures and processes in place that enable it to identify and benchmark itself against relevant best practice and to track and report compliance against required standards and targets. The following quality assurance groups will play a major role in delivering effective clinical governance.

1. Patient safety

This is the first dimension of quality care, namely *'the avoidance of unintended or unexpected harm to people during the provision of health care.'* The patient safety group must monitor the safe provision of care and provide assurance (in the form of risk reporting, incident analysis and mortality/morbidity reviews) to the quality assurance steering group.

2. Patient experience

The quality of the patient experience must be paramount, including the way in which personal care is delivered with compassion, dignity and respect. The patient experience group is tasked with analysing and understanding patient satisfaction in respect their own experiences whilst under the care of the trust. Regular and systematic assessment will take into account the friends and family test and patient reported experience measures, as well as learning from complaints (and compliments).

3. Clinical effectiveness

The Department of Health (DH) defines clinical effectiveness as: '*the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice*'.

The clinical effectiveness group, therefore, must have a thorough understanding of success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement, national and local clinical audit, local quality improvement initiatives and the implementation of evidence-based clinical standards (e.g. NICE quality standards and indicators). Just as important is the effectiveness of care from the patient's own perspective, which will be measured through patient-reported outcomes measures (PROMs).

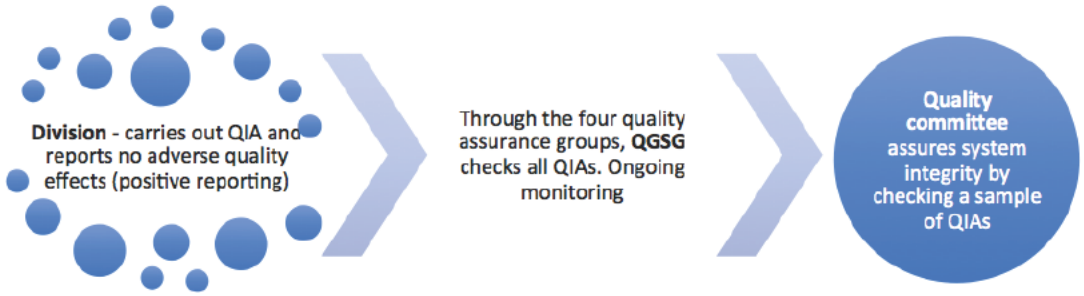
4. Risk and compliance

Whilst not included within Lord Darzi's three dimensions of quality, it is of critical importance that the trust takes a proactive approach to risk management through a robust Risk and Compliance Group, in order that the necessary processes are in place across the organisation to ensure compliance with statutory requirements, and to protect patients and staff.

The quality governance steering group would have as their prime mission assurance against the quality elements from the BAF, and to ensure that the trust executive had regular reports on quality issues, oversaw the development of quality management in the trust and escalated any issues of concern to management. The board's quality report will come from the executive team, heavily informed by the quality governance steering group as part of the quality management system for the trust. As described in Figure 1 previously, the trust board, through the quality and audit committees, would test and scrutinise this system. The reports from the executive will assure the board of the sufficiency of the system such that issues of concern are being addressed. This would also provide a reliable framework for internal audit to programme in their work on the broader aspects of good governance. Figure 5 explains through an example how a quality issue could be dealt with within this reporting and assurance structure.

8) Darzi A; 'Next Stage Review'; Department of Health, London; 2008

Figure 5 - Example of quality management responsibilities: quality impact assessments (QIAs) for cost improvement programmes (CIPs)



he quality governance steering group would need, as an early task, to locate the work of any other quality management (or 'feeder') groups under the four quality assurance groups. Some of these feeder groups would have useful contributions to make to more than one of the assurance groups. An annual cycle of business for each of the groups would need to include 'commissioning' work from the relevant feeder groups against an agreed timescale. Additionally, the quality governance steering group would help to triangulate what the different clinical governance disciplines were reporting, in the same was as the 'Triangulation Group' does in Western.

Figure 6 below describes an example for the principal working relationship between feeder groups and the quality assurance groups.

Figure 6 – Example of how feeder groups could be arranged

Patient safety	Patient experience	Clinical effectiveness	Risk and compliance
• Decontamination • Infection control and prevention • Serious incidents • Medical gases • M and M • Resuscitation • Transfusion	• Adult and child safeguarding • Complaints • PALs	• Medicines management • Non-medical prescribing • Drugs and therapeutics • Anti-microbial stewardship • Medical devices • Nutrition • Clinical audit	• Research governance • Information governance • Records management • Information assets management • Data quality • Policy review • Health and Safety

C. The new divisions

The development of the new divisions is the new element that will bring together an unwieldy structure of 12 clinical directorates, each with varied numbers of specialties or other groupings under them. Initially, the clinical directorates will be kept, although it is expected that as the new divisions pick up the pace they may organise themselves along different lines to the current clinical directorates. For example, they may take more of a 'care group' approach to grouping together those specialties or other services in a way that makes sense in terms of managing care delivery.

The divisions will be led by Chiefs of Service who will report to the new COO, and have reporting to them the other two partners in the triumvirate. We understand that there will be professional accountability for nursing and midwifery members of the triumvirates to the Chief Nurse. The Chiefs of Service will be part of the trust executive.

In terms of clinical governance, we recommend that each division will need to rapidly develop so that, against the divisional clinical governance maturity matrix set out in Figure 7 below, level 2 is being consistently achieved in each division. This needs to be achieved by March 2018 and we recommend an intense and at pace 'development by doing' programme whereby each of the monthly divisional governance meetings is used as a step to achieving level 2 (see Recommendation R27).

Good Governance Institute

Maturity matrix to support effective governance meetings at divisional or clinical directorate/care group level

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

VERSION 1.0 OCTOBER 2016

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Initial achievements evident	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistent achievements
IMPLEMENTING BEST PRACTICE E.G. NICE GUIDELINES	No	Knowledge about best practice sits with individuals. Having a structured way to share best practice uniformly is accepted but not developed. The review of new best practice guidelines is often delayed. Clinical guidelines are not routinely updated to reflect best practice until after the clinical guideline has expired	Process in place to ensure new national guidelines come to the attention of divisions and specialties and gap analysis is performed. Process for measuring and monitoring best practice identified, but not yet implemented systematically. Where best practice is not implemented this is on the risk register but with limited plans to address gaps	New national best practice is being systematically picked up for adoption by the division/specialty. Evidence of local situation collated and evaluated. Multiple examples of best practice being picked up and locally implemented within last 24 months. Gaps in compliance are routinely captured on the risk register with action plans to close gaps agreed and implementation monitored	Application of best practice guidelines systematically monitored and results discussed. Results shared between specialty and division, and variances with action plan reported upwards. Evidence of positive clinical outcomes and experience for patients as a result of the consistent application of national guidelines	Systematic application of best practice locally is routinely reported and learning points shared within division and across divisions. It can be consistently demonstrated through monitoring that there is a delivery of excellence in care and experience. Evidence that services provided by division/specialty are systematically improving year-on-year	Contribution to the development of national and international standards by being recognised for publishing examples of excellent practice or other peer review recognition. Examples of other organisations learning from this service
CQC REGULATION	No	Division and specialty leadership promote the importance of clinical, quality and regulatory standards more broadly with staff. Staff are aware of CQC quality domains and ratings	division/specialty has mapped its compliance against all relevant standards and is aware of gaps. This process has involved staff and there are dynamic performance measurements in place e.g. clinical audits. Quality dashboards have been developed at both division and specialty level and they are aligned to the CQC quality domains	Compliance mapping is systematic and kept up to date. Action plans have been developed and implementation progress is being managed. Results and issues are shared in the division/specialty. There are action plans in place to improve performance against any gaps in CQC compliance. Trust wide rolling programme of peer review inspection	Compliance reviews include an external to the division/specialty component. Evidence of inter-division/specialty sharing of improvement points. External recognition being achieved, for example CQC 'good' rating for service concerned	Inter-division working on standards compliance is achieving consistent results for the trust in broad-theme areas e.g. patient safety, patient experience. Year-on-year consistency or improvements can be shown. Results comparison with other trusts used as a spur for adopting better compliance against standards	CQC rating of "outstanding" in majority of specialties. Other organisations learn from the work. Trust benchmarks in upper decile for standards compliance nationally
RISK MANAGEMENT	No	Staff are aware of the trust's risk management policy and understand key elements of this e.g. risk assessment, risk escalation, etc. This is included within the induction process. New risks are being entered into the risk register and the division/specialty have started to review these	Evidence risks are being reviewed and calibrated, and action plans agreed. Examples of appropriate escalation of risks. Risk registers systematically reviewed at division and specialty level, and risk informs quality improvement activity. There are examples of risks being escalated to the corporate risk register. Risk management system externally tested and recognised, through internal audit	Risk identification is proactive and a key part of annual business planning and quality assurance cycles. SMART action plans are in place for all risks. division and specialty leadership are fluent in trust's risk management approach, and understand trust's risk appetite approach. There are examples of different divisions and specialties collaborating to mitigate risks	No risks overdue for review on the division or speciality Risk Register. Risks are triangulated between divisions to identify corporate issues. Multiple examples of risk escalation with concomitant actions taken, and of risk score reductions. division and specialty leadership confident that risk system is picking up issues they consider important and relevant to better patient care. Staff are aware of the top risks within the division/specialty, and what is being done to mitigate these risks	Internal audit provide positive assurance that risk management is robust and adding value. Staff involved in peer learning exercises within the trust and externally. Evidence of consistent risk reduction through the completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of CIPs shown to be accurate over time	Trust benchmarks with top decile for achievement of risk management training. Improvements derived from risk management shared with other organisations and recognised by peers. Contribution by trust to national patient safety learning efforts
PATIENT SAFETY AND MANAGING INCIDENTS	No	Incident reporting understood by all staff and considered to be valuable. Roles and responsibilities of staff at division and specialty level in relation to incident reporting are clear. Evidence of staff reporting incidents of moderate harm and above. Incident reports standing agenda item at division and specialty clinical governance forums	Evidence of reporting high numbers of no and low harm incidents. With only few exceptions, incidents reviewed within policy timescales. Duty of Candour discussions evidenced. Staff know about 'learning from incidents' events/communications. SI investigations are often overdue. Further information requests are frequently received back from commissioners	Quality checking for completion and action plans of incident reports. Feedback is provided to staff on actions arising from incidents. Staff routinely attend patient safety training and SILAG. Incident reporting not dominated by one staff group only. SI investigations are routinely completed on time and only occasionally overdue. Further information requests are occasionally received from commissioners. NRLS reporting is in line with the national average	Improvement examples rooted in reported incidents available. Lessons learned discussed from incidents in other divisions/specialties. Broader local and national patient safety intelligence considered. Duty of Candour compliance tested routinely. No out of date SI investigations within division/specialty. NRLS reporting is in the upper quartile	Staff systematically involved in peer learning exercises within the trust and externally. Examples of harm reduction demonstrable. Examples of patient/carer involvement with patient safety initiatives available within last 12 months. No breaches of internal SI deadline in past 24 months. NRLS reporting has been in the upper quartile for the last 12 months	In the upper quartile of NRLS reporters. Examples of harm reduction achievements externally shared. Staff routinely participate in broader local and national learning around patient safety. Peer recognition around patient safety initiatives

Figure 7 – Clinical governance in the divisions

PROGRESS LEVELS ▶ / KEY ELEMENTS ▼	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Initial achievements evident	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistent achievements
PATIENT AND CARER FEEDBACK	No	Staff understand the 'Friends and Family Test', the role of PALS and the local complaints process. The division/specialty has considered these as part of a broader range of potential feedback mechanisms for patient and carer feedback. Complaints are responded to, but often outside the time period agreed with the complainants	Patient and carer groups within the division/specialty have been identified. Positive and negative patient stories are considered at division/specialty governance meetings. Patient and carer feedback is given the same profile as other elements of quality in division/specialty reporting and discussion. More than 50% of complaints are responded to within time	Complaints and PALS review by the division/specialty look at content as well as process performance/uptake metrics. There is a consistent approach to advertising feedback mechanisms to patients and carers, and staff are confident to solicit patient and carer involvement in local initiatives e.g. patient forums, surveys, focus groups etc. More than 90% of complaints are responded to within time	There are examples of improvements achieved that were initiated from patient or carer feedback. Broad themes identified from patient and carer feedback are included in division/specialty improvement plans. Feedback issues are shared between divisions and specialties. When asked, front line staff can recall examples	Improvement plans systematically are checked against, and generated by, patient and carer feedback mechanisms. Improvements in examples of patient experience are demonstrable over the last 24 months. Patient feedback meaningfully contributes to other elements of quality management, e.g. the risk registers	Patient and carer feedback initiatives have been recognised externally. Patient and carer advocates use the work of the division/specialty to suggest improvement mechanisms to other organisations
IMPROVEMENT, IMPLEMENTATION AND LESSONS LEARNED	No	Staff understand that systematic improvement processes are part of business as usual. division/specialty leadership have considered how to use assurance and other governance mechanisms as the basis for the local improvement plans. The skills for implementing improvement are recognised and form part of overall staff evaluations/recruitment strategies	Quantifiable action plans are part of the approach to compliance and quality management. Success criteria are included in action and improvement plans. Selected staff have received training in improvement techniques. Management forums have time set aside to consider improvement approaches	Regular staff forums have time set aside for sharing improvement work, lessons learnt and changes to practice. Staff understand routes by which they can surface improvement ideas. When ideas have been offered there is feedback to advise on the adoption or otherwise of ideas offered. There are multiple examples of practice changing as a result of improvement plans, and lessons learned. These transcend single divisions/specialties	Staff feedback confirms that improvement work is valued, and recognised as everyday within the division/specialty. Improvements, including CIPs, have a track-record or matching plans. Quantifiable dividends from improvement work is identifiable. Several care pathways have developed as a result of specific improvement interventions. Improvement science capacity has been developed locally through training and/or recruitment	There is a consistent track-record of tangible and multiple examples of learning between divisions and specialties. Improvement initiatives that derive from learning from outside the organisation have been delivered. Future plans are developed on the expectation of continuing improvement work and this extends beyond financially-related benefits to issues such as improvement to patient experience, harm reduction, etc	External peers have recognised and copied improvement approaches from the division/specialty. Improvement work has been written up and shared at external events or by publication. Other organisations have recognised the contribution of work undertaken by us in their own improvement work
CLINICAL AUDIT	No	Clinical and non-clinical staff recognise the value of clinical audit, and appropriate time has been quantified for involvement in this. The division/specialty has developed an annual plan for supporting clinical audit activity and there is a division/specialty forum established for sharing results and learning points	Specialties have a clinical audit programme which is coordinated by the division, and the division has an overall clinical audit plan as part of improvement work. The clinical audit plan includes a balance between national and local audits. Clinical audit activity is rooted in areas where risk, or improvement potential, has been demonstrated	There is evidence of action being taken to improve clinical practice at ward/team level in response to clinical audit results. Some cross-specialty clinical audits undertaken, with joint improvement plans in place. The division actively steers clinical audit activity as part of its improvement work	There are quantifiable examples of benefits as a result of clinical audit activity, such as improved compliance, better use of resources, care pathway modification, etc. There are examples of inter-division/specialty learning. There is a tangible connection between clinical audit and other clinical governance mechanisms, for example clinical audit appears as a consistent action plan item within risk registers and SI action plans	Quantifiable benefits from the clinical audit plan is systematic over at least 24 months. Where audits are comparative, there is a forum where the results are discussed and benchmarking takes place. Lessons are sought from higher-performers. Clinical audit is used as a dynamic measurement of performance to support overall compliance assurance and improvement programmes	There are examples where improvements that have used clinical audit have been adopted by others. There is full compliance with all mandatory national audits. Peer-review publications authored by division/specialty staff have sued clinical audit, or the equivalent for scientific conference presentations. There have been contributions to the national development of clinical audit, for example by involvement with HQIP
MORTALITY	No	Case note reviews for patients who have died are undertaken on an ad hoc basis. The MDT is not routinely involved in case note review, which is sometimes undertaken by individuals	Case note reviews is standardised and follow agreed best practice. More than 50% of deaths in the division's care are reviewed, and review is usually undertaken by a team rather than an individual	All patient deaths are reviewed by the MDT at a dedicated session. The division receives summary data from the trust which they review with the aim of abstracting issues relevant to the division. Nationally recognised measures are used to measure the quality of care and preventability e.g. Hogan scale, NCEPOD standard	We can identify changes in practice that are routed back to case review. There are action plans to pick up issues identified by mortality reviews (reviews from within the division and for the trust overall)	There have been reductions in mortality over the last 24 months as measured by HSMR and SHMI	Our HSMR and SHMI is 90 or less. The work on mortality at the trust has influenced care and pathway design in other organisations

Divisions will need to develop an internal governance structure with both leadership and resourcing around governance activities and disciplines clearly identified. The relationship with, and future of, the central clinical governance team is key to making this work. There are essentially two pathways that we would suggest be considered:

1. **Separate central and divisional capacity:** the central and divisional teams are essentially discrete, although they obviously work closely together. The central teams bring together the reports from the divisions for the quality governance steering group, provide discipline-specific expertise and provide support to the divisions in helping to share ideas and issues between the divisions
2. **Matrix working:** whilst there are discernible central and divisional governance teams, there is a degree of sharing of resources and responsibilities. For example, a member of staff working in the central patient safety team might also have specific responsibilities within certain divisions (acting as a governance resource for the divisional triumvirate in one or more divisions); and an individual principally working in a division might have a central team (pan-trust) role on an aspect of clinical governance about which they have developed a particular expertise. An example might be a clinical lead who has developed specialist skills on mortality measurement

Both approaches may work and there are arguments for each. Conceptually, option 1 is simple to understand and gives all players delineated jobs to get working on. Option 2 provides interesting possibilities for creating rewarding and high-profile clinical governance roles for staff interested in developing the divisional role too (see recommendation R28).

Whichever option is chosen, the trust needs to ensure that divisions develop the skills and confidence around clinical governance. We recommend that at this early stage this is done by each division identifying leads and a way of resourcing activity (how this is achieved depends on whether option 1 or 2 above is chosen) for each of the following main elements of clinical governance:

- *Patient safety, including managing incident reporting*
- *Clinical effectiveness, including clinical audit*
- *Patient experience, including PALS issues and complaints*
- *Risk management, including accepting risks onto the risk register*
- *Compliance issues, including CQC readiness and compliance with trust policies*

These elements of clinical governance work mirror the four quality assurance groups.

Standard agendas and reporting arrangements will be developed for each of these clinical governance streams, together with an annual cycle of developmental and assurance business. The spine of the divisional clinical governance activity will be monthly divisional governance meetings. Clinical governance will have prominence in planned quarterly divisional performance meetings with the trust executive.

It is essential for robust quality administrative and committee processes to be embedded within the new divisions from the outset as this will provide a sound assurance framework moving forward. Consistent BSUH 'house-style' templates should be developed for all divisional meeting agendas, minutes, action logs and reports.

Appropriate training and development should be offered to administrative staff who have been identified to provide support to various divisional committees and groups, with professional guidance being provided by the trust secretariat to ensure quality and consistency. Chairs of divisional level committees should also be offered training and development as they perform a pivotal role in ensuring that agendas are properly constructed, minutes are accurate and business conforms to the trust's cycle of quality assurance.

The membership of divisional committees should be carefully considered and should be limited to those who are deemed essential (not just desirable or representative) to attend and to make an informed contribution to discussion and debate. In this way, duplication of effort will be minimised. Approved minutes/action logs of all meetings should be made available more widely to relevant divisional staff as part of a wider communication and socialisation strategy.

Divisions themselves are planned to be of significant size and complexity. Each will in itself be organised as a series of clinical directorates or care groups, and at this level too we would expect monthly clinical governance meetings to be taking place. Figure 8 describes best practice for clinical governance meetings and is useful for use at both the divisional and directorate/care group levels (see Recommendations R29 and R31).

In order to implement a functioning assurance system as quickly as possible, we have set out at Appendix I a proposed accelerated development plan for the new divisions. This includes the development of a symbiotic relationship with the central team.

Good Governance Institute

Maturity matrix to support effective governance meetings at divisional or clinical directorate/care group level

PROGRESS LEVELS / KEY ELEMENTS	0 NO ACTION	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Progress becomes mainstreamed	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistend achievements
STRUCTURE	No	Structure developed and agreed. Shared with all staff in divisions/specialty. Roles and responsibilities agreed	Structure across whole divisions discussed at divisions and specialty level, with terms of reference agreed for each standard meeting	Structure shared across all divisions, and structure of other divisions and specialties reviewed and discussed to identify any useful learning points	Annual review of meeting's work confirms positive added value. Structure refined. Task and finish groups set up for one-off projects of work	Structure, with amendments and improvements, has been working for 24 months. Evaluation of structure as remaining fit for purpose two years running	Structure externally recognised as adding value. Other organisations have reviewed the structure as a possible model for their own structure
ENGAGEMENT	No	Attendees for meetings defined and informed. Quorum defined	First three meetings held and quorum maintained. Meeting etiquette discussed and agreed.	No surprise non-attendees from core members at last three meetings. Apologies with reason for no show always given. Substitutes usually attend for planned no shows	At least 75% of core membership have attended last three meetings. Examples of staff initiated issues being picked up at meetings. Membership reviewed and if needs be developed	Attendance at meetings reviewed for past year and 75% attendance maintained. Refinement to membership based on cycle of business. Engagement by divisions and specialty staff is recognised by external parties as a mark of good practice e.g. CCGs and CQC	The working methods of the divisions/specialty has been used by other organisations to help develop their own approach. The engagement by staff in the governance process has been promoted in a peer review forum as national best practice
RECORDING AND ACTION PLANS	No	Standard format for meeting recording discussed and agreed. This includes adoption of trust templates	Meeting notes and action plans for last three meetings drafted and distributed within five working days	Meeting notes and action plans for last three meetings reviewed at following meeting, with actions initiated against majority of action points. Commitment to minimise carried over items	Action plans are reviewed and examples of tangible improvements have been identified. Meeting records are routinely reported to the next tier up. Meeting recording is characterised as timely and lean by those attending meetings	Action plans are systematically being met, with evidence of tangible improvements to practice, compliance or meeting targets. The recording of meetings provides reliable evidence of activity for third parties e.g. internal audit, the CQC, assurance to CCGs	Meeting and action plan recording is recognised as being best practice by external parties e.g. commendations from auditors, mentions in CQC reports. Examples of how activity is recorded are used to influence other organisations
CONTENT AND CYCLE OF BUSINESS	No	Standard agenda agreed, to include consideration of trust template, and first meeting held. Dates organised and advertised for coming three months	Outline annual cycle of business discussed and developed, and shared with next tier up	Annual cycle of business finalised and published with divisions and specialty. Group is "commissioned" by group it reports to.	Annual cycle of business reviewed and updated each meeting. Contributions to cycle of business from work of other specialties and/or divisions, as well as tier above	The BAF relies on the work of meetings to migrate assurance to board level. The content of meetings matches the external compliances the organisation needs to evidence	Other organisations are using the work of the divisions/specialty to provide example templates for their own governance meetings. The cycle of business is commended by external parties such as internal audit,
COMMUNICATION	No	Rudimentary communications materials developed and circulated e.g. structure charts, round robin email, posters	Notes and action plans for last three meetings available for staff. Method for cascading news from meetings agreed	Cascading system (Hotspots) successfully used for last three meetings. There are examples of hotspots being populated by examples identified at meetings	Hotspots are routinely populated by issues identified at meetings. Staff feedback about the usefulness of communications is influencing the development of future communications approaches	Feedback from staff is starting to shape elements of the focus of meetings. Leadership of the divisions/specialty is confident that they are routinely informed about the work of colleague divisions and specialties	Communication methods are shared with other organisations or identified through best practice awards. Feedback from other organisations shows that others have found the communications approaches have influenced their own local development

Figure 8 – Maturity matrix to support effective governance meetings at divisional or clinical directorate/care group level

5. Conclusion and recommendations

GGI thanks BSUH for asking us to review your governance arrangements and recommend next steps. The trust has the golden opportunity of a new start, and as so much in terms of the overall management structure is new this year we believe that much can be achieved. Successful delivery to the governance of the trust will not only provide a platform for better performance, but will also help address the introduction of an accountability culture.

The pace of change we are recommending is rapid, and many of our recommendations require a significant re-think about how governance has been understood in the past. A real focus on good governance leading up to the CQC inspection next year will really support the cultural and performance issues that have placed this trust in special measures. This will be a significant task, but one that will engender pride and confidence as well as structural improvement.

In detail, our recommendations are as follows:

R1 The trust management should agree and publish what they mean in terms of 'earned autonomy' as it relates to governance at the divisional level. For consistency, we would suggest this is tied into an incremental improvement against the relevant maturity matrix

R2 To signify individual responsibility for clinical governance, all job descriptions for clinical leaders, the triumvirates within the divisions, clinical directors and specialty leads should include specific reference to accountability for clinical governance. All appraisal and personal development planning should support this, with specific goals for all relevant members of staff

R3 The BAF needs re-writing and should be worked on and agreed by the board as part of board development. The new BAF should be explained to the newly-appointed divisional triumvirates, and in particular, the assurance framework should be the script for the quality management system of the trust

R4 A skills and capability review of all individual directors should be carried out against the NHS board directors' competencies matrix. The results should be fed into a succession plan for the board and any future board development plan

R5 Chairing board sub-committees' is a critical task and the trust should only appoint experienced individuals with sufficient skills and knowledge to chair board sub-committees

R6 The new quality management structure recommended in this report should be implemented (i.e four new quality assurance groups reporting to a new quality governance steering group)

R7 No management groups should report to board sub-committees'. All management groups should have reporting lines up through management. The assurance role of board sub-committees', organised through the BAF, should be emphasised

R8 Any new governance arrangements should be considered in terms of scalability within a group structure

R9 The board should consider and agree its risk appetite for each strategic objective, in order that this can guide the development of controls and assurances

R10 The board's schedule of delegation and reservation should be reviewed in the light of the recommendations to change the trust's quality management structure

R11 The term 'committee' should only be used for those committees that directly report to the board

R12 Board sub-committees' should be limited to audit, remuneration and appointments, quality, finance and investment and charitable funds. All other sub-committees' of the board should be time-limited task and finish groups

R13 As part of management's review of the 3Ts programme, consideration should be given to recommending that this current board-reporting group should become a task and finish group

R14 The cycles of business for the board and all sub-committees' should be linked to the BAF

R15 The cycles of business for the new quality governance steering group and the four new quality assurance committees should be linked to the BAF

R16 The next annual board sub-committees' review should test whether the board are content with the level of assurance each sub-committee is providing, and how this supports the BAF

R17 The board should assess itself against the NHS trust board maturity matrix, and have as a development aspiration to reach at least level 3 by the end of March 2018

R18 There should be an at-scale communications programme to help staff understand the new quality assurance system, to include basic clinical governance expectations such as incident reporting, the risk management system, the Duty of Candour and patient experience

R19 The clinical governance capacity and capability of the trust should be developed to achieve level 3 on the clinical governance maturity matrix by the end of March 2018

R20 Any 'feeder groups' should be formally related to one of the quality assurance groups

R21 The structure of the corporate risk register, particularly in relation to action plans, should be reviewed

R22 Whilst the risk management strategy was agreed in 2016, it is flawed and will not reflect the current quality management structure. It needs to be replaced by the end of March 2018

R23 The new patient safety group should maintain a watching brief on incident reporting levels with the aim that these match the appropriate national norms within 12 months

R24 Incident investigation skills should not reside in a small central team. A much wider pool of incident investigators should be developed and used

R25 A new clinical effectiveness strategy should be developed and agreed by the end of March 2018 and this should incorporate national best practice as aspirations for the clinical audit programme

R26 A patient experience strategy should be developed and agreed by the end of March 2018

R27 To support the divisions develop a high standard of clinical governance from the outset, a 'development by doing' programme (as set out at Appendix I) should be delivered

R28 The trust should identify how clinical governance will be led and resourced going forward. Options could include the 'separate central and divisional capacity' model of the 'matrix working' options that we have described

R29 The governance meetings matrix should be adopted to support the divisions and clinical directorates better deliver their governance accountabilities

R30 The roles for the quality and audit committees should be developed along the lines described in figure 1. Internal audit should have sight of this report to support their work in regard to quality governance as part off the annual programme of internal audit

R31 The trust board should receive a progress report against this report's recommendations in April 2018

Appendix I

A development programme for clinical governance in the new divisions

The going live date for the new divisions is planned for 1 December 2017. In this report we have taken the end of March 2018 as a useful marker for achieving better governance at all levels. With the CQC returning to the trust some time shortly after April 2018, it is desirable to ensure that the new system is up and running prior to their arrival, so that they have the opportunity to inspect the organisation as the board intends to run it.

Between 1 December 2017 and 31 March 2018 there are four complete months. We recommend that the monthly cycle of governance meetings within the divisions starts in January 2018, so that the four month period enables one month's preparation for the first of these, and then three cycles of one month. During this time a 'development by doing' programme can be put in place to use the first three monthly governance meetings as the deliberately designed focus for improvement, using the 'plan, do, study, act' (PDSA) approach.

It is critical for the reform and development of the central team to run in parallel with the development of the new divisions. The trust will need to decide as soon as possible whether option 1 or 2 is to be adopted in terms of the relationship between the central team and the divisions. It will not be possible for the clinical directors to make an informed decision about leading governance until this decision is taken.

A four-month programme is recommended as follows:

Divisions	Central team
Month 1	
Agree the terms of reference (TORs) and membership of the divisional governance meeting.	Agree the TORs and membership of the four quality assurance groups and the new quality governance steering group.
Within the parameters set out in this report, identify who is to lead on each of: o Patient safety o Clinical effectiveness o Patient experience o Risk management o Compliance issues and how are these activities going to be resourced.	Agree with the divisions any resource sharing/ transfer arrangements, and any areas of joint working. Complete any new portfolio assignment for lead clinical governance portfolios.
Identify dates for divisional governance meetings that match the cycle of business of the new quality assurance groups.	Set up the cycle of business for the four quality assurance groups and the new quality governance steering group. This should be informed by the assurance identified in the BAF.
Review the structures and cycles of business for clinical governance-related groups with reporting clinical directorates.	Review the various feeder groups and assign these to a principal parent quality assurance group. Some feeder groups may have a working relationship with more than one quality assurance group (e.g. medicines management).
Relevant external partners, for example the local CCGs and NHS England, will need to be informed about the new quality arrangements and who is responsible for what going forward.	

Month 2
Joint externally-facilitated workshop for all leads of the governance disciplines within divisions (eg patient safety, clinical effectiveness, etc) and the corresponding leads from the central team. This first workshop will introduce all to the relevant matrices that are guiding development aspirations, and be the opportunity for all to meet each other in their new roles. Each month will focus on a particular theme and, at the same time: • prepare for the first/next divisional governance meetings • prepare for the first/next quality assurance meetings • prepare for the first/next quality governance steering group Special theme for month 2: **Introducing standard meetings and reporting templates.** Discussion at the workshop will be informed by an understanding of the BAF as the source of the main assurances required by the board.
Each governance meeting will be observed, and facilitators will feedback on performance to individuals.
Month 3
A second externally-facilitated joint workshop for all leads of the governance disciplines within divisions (eg, patient safety, clinical effectiveness, etc) and the corresponding leads from the central team. The workshop will help participants review (having been given prior feedback) how the first set of meetings went, identifying any learning and action points, and jointly working on solutions. This will help participants prepare for the second monthly meetings and focus on the month's special focus which will be the **risk management system** and working with the risk registers.
Each governance meeting will be again observed, and facilitators will feedback on performance to individuals.
Month 4
A third and final externally-facilitated joint workshop for all leads of the governance disciplines within divisions (eg patient safety, clinical effectiveness, etc) and the corresponding leads from the central team. The workshop will help participants review (having been given prior feedback) how the second set of meetings went, identifying any learning and action points, and jointly working on solutions. This will help participants prepare for the third monthly meetings and focus on the month's special focus which will be preparation work on **compliance with CQC** expectations, and in particular, the well-led framework. Any gap analysis the trust has done against the well-led framework will be source material for this workshop. The workshop will also include a review of the divisional governance matrix to check progress to date
Each governance meeting will be again observed, and facilitators will feedback on performance to individuals.
An end of term report will be prepared from the facilitators with next steps for on-going development of the divisions and the central team.

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