Good Governance Institute

Brighton and Sussex University Hospitals NHS Trust (BSUH)

Rapid review of clinical governance in divisions

Draft report - Strictly Confidential

September 2018

Brighton and Sussex University Hospitals NHS Trust (BSUH)
Rapid review of clinical governance in divisions

Client:	Brighton and Sussex University Hospitals NHS Trust (BSUH)
Project name:	Supporting the implementation of the quality management structure
Date:	September 2018
Authors:	[redacted]
Reviewed by:	
Designed by:	

info@good-governance org.uk www.good-governance.org.uk

GGI Limited Registered office (Registered in England and Wales company number: 06836117) and GGI Development and Research LLP (Registered in England and Wales company number C384196): Old Horsmans, New Road, Sedlescombe, Battle, East Sussex, TN33 0RL, United Kingdom. GGI Limited and GGI Development and Research LLP are the trading bodies supporting and taking forward the work of the Good Governance Institute (A not-for-profit company registered in the Republic of Ireland company number 590301) Registered office: The Black Church, St. Mary's Place, Dublin 7, D07 P4AX, Republic of Ireland.

1. Context

1.1 The review was conducted during the period: 28-31 August 2018 at the request of the Group Chief Medical Officer and BSUH Medical Director in order to assess divisional clinical governance structures and systems in advance of a full inspection visit by CQC in late September 2018.

1.2 In December 2017, the Trust moved from 12 clinical directorates to five Divisions: Central Clinical Services; Surgery; Medicine; Specialist Services and Children's and Women's. A new clinical governance structure (as recommended by the Good Governance Institute (GGI)) was put in place, with each division having its own Clinical Governance Meeting (which takes place monthly), reporting to the bi-monthly Quality Governance Steering Committee (QGSG) (chaired by the Chief Medical Officer), which in turn reports to the Trust Executive Committee (TEC).

1.3 To reinforce the new quality structure that the Trust has introduced, GGI has continued to work intensively with the divisions in the form of workshops and individual meetings, which has helped to inform the design of common clinical governance tools and templates. In addition, we were asked to assist with the mapping and subsequent rationalisation of quality governance structures, including developing the standardisation of directorate/service level reporting into Divisional clinical governance meetings. This has enabled the identification of any gaps in reporting, and also highlighted examples of good practice that have been shared more widely as part of Trust-wide learning.

1.4 Standard clinical governance agenda and report templates have been enthusiastically adopted, and complied with, by divisions (and directorates / services). A governance 'hotspots' reporting template was introduced which is an effective way of sharing key messages/learning with staff across and between divisions – this remains to be fully embedded. We provide below an evaluation of how divisions have self-assessed against the quality and clinical governance Maturity Matrix (see Annex I).

2. Methodology and scope

2.1 The rapid review methodology conformed to good quality governance best practice and consisted of meeting observations, focus group sessions and a series of 1-1 semi-structured interviews with divisional triumvirate teams and other key governance staff within divisions, mainly in small group or paired format.

2.2 As part of the evidence gathering exercise, the GGI Maturity Matrix to support the development and improvement of quality and clinical governance in divisions was used in interviews, divisional staff being asked to assess their clinical areas against eight key elements against a 6-point scoring scale.

3. Divisional evaluation

3.1 Central Clinical Services (CCS)

The division has embraced the new clinical governance model well. We observed a meeting of the CCS monthly Clinical Governance Meeting on 23 August which was a well-attended and participative meeting and which conformed to the new structured agenda. All directorates gave individual clinical report updates using the new templates that had been introduced and many attending the meeting commented on how useful the new system was in concentrating time and effort on key issues (top three headline risks; item for sharing/learning). This was a recurring theme with other divisions.

At the end of the meeting, a summary of issues requiring escalation was itemised. The annual business cycle template had been completed in part, it being accepted that this would become more comprehensive in scope over the next few months, as with other divisions.

As an example of shared learning, the Lead Nurse from Cancer gave a short presentation on a new online Friends and Family Test (FFT) feedback system that had been introduced and which was being rolled out, Trust-wide.

3.1.1 Self-assessment against maturity matrix core elements

Implementing best practice (e.g. NICE guidelines)

Firm progress has been achieved in that there is evidence that new national best practice is being systematically addressed and adopted. The risk register is being used proactively to capture any gaps in compliance, and appropriate action plans are in place by way of mitigation.

CQC regulation

Firm progress has been achieved in that detailed improvement action plans have been developed and implementation is being systematically monitored and managed. Issues are shared within the division as points of learning and a Trust-wide rolling programme of peer review is in place.

Risk management

Firm progress has been achieved by the divisional leadership in establishing a proactive system of risk identification which forms a key part of the annual business planning and quality assurance cycles. There is a good understanding of the wider Trust risk management system and how the division feeds into this.

Patient safety and managing incidents

Firm progress has been achieved. Serious incident (SI) investigations are competently managed within agreed timescales. Quality checks are systematically performed in respect of incident action plans, and staff routinely attend patient safety training.

Patient and carer feedback

Developing progress has been achieved in that specific patient and carer groups within the division have been identified. There is evidence that both positive and negative patient stories are considered as part of the division's wider learning. Complaints are dealt with systematically, with more than 50% of complaints being responded to within agreed timeframes.

Improvement, implementation and lessons learned

Firm progress has been achieved. Evidence exists of regular staff meetings and forums at which time is dedicated to learning: sharing lessons learned and discussing changes to clinical practice. Open and transparent communication channels exist to allow staff to surface improvement ideas which are then discussed more widely within the division.

Clinical audit

Developing progress has been achieved in that an overall clinical audit plan has been developed (balanced between local and national audits) as part of an improvement work programme, which is used to disseminate learning. It is anticipated that firm progress will have been achieved against this element within 6-9 months.

Mortality

Firm progress has been achieved in that all deaths are reviewed by the multidisciplinary team (MDT) at a dedicated session. Summary statistics received from the Trust are comprehensively reviewed. Nationally recognised measures are used to evaluate quality and preventability.

3.2 Children's and Women's

The division was rated 'outstanding' in the last CQC inspection. The division has strong leadership and has an experienced, designated clinical governance co-ordinator (risk midwife) based in Maternity. There is uniformity across the directorates (Gynaecology, Obstetrics and Paediatrics) in terms of the structure of the quality and governance agenda and reporting, which has become well-embedded in a short period of time. Staff have welcomed the clarity of focus that the new structure has produced.

3.2.1 Self-assessment against maturity matrix core elements

Implementing best practice (e.g. NICE guidelines)

Mature results are being achieved through the application of best practice guidelines, which are systematically being monitored and discussed. Learning points are shared both within the division and across other clinical areas. Strong evidence exists of positive clinical outcomes for patients as a result of the consistent adherence and application of national guidelines.

CQC regulation

Exemplar status has been achieved as a consequence of the division being rated 'outstanding' across its specialties. There is evidence that other organisations have learned from the work of the division.

Risk management

Results are being achieved by the divisional leadership in that no risks are overdue for review on the risk register. Evidence exists that the risk system is being used proactively to identify issues that can improve patient care. Staff can articulate the top risks within the division and what actions are being taken to mitigate these.

Patient safety and managing incidents

Results are being achieved with improvement examples being routinely discussed and shared within the division and more widely. There is evidence that Duty of Candour compliance is robust and that no out of date SI investigations exist.

Patient and carer feedback

Results are being achieved in that specific improvements have been made as a consequence of direct patient and carer feedback. The division is proactive in incorporating broad themes form patient and carer feedback into its improvement plans, and shared learning is strong.

Improvement, implementation and lessons learned

Results are being achieved, in that staff confirm that improvement work is valued and embedded as part of everyday working. Evidence exists of several care pathways having been developed as a result of specific improvement interventions.

Clinical audit

Results are being achieved related to the quantifiable benefits arising out of clinical audit activity (e.g. improved compliance, better use of resources, care pathway modifications). Tangible evidence exists of the connection between clinical audit and clinical governance mechanisms.

Mortality

Results are being achieved. There is evidence that changes in clinical practice are routed back to case reviews, with action plans in place to identify learning issues, both from within the division and more widely.

3.3 Medicine

The division is large and complex with 7 departments (directorates): Emergency Department, Acute, Respiratory, Endocrinology & Diabetes, COTE, ID/HIV and Dermatology. The division has begun to embed the new clinical governance framework and held an off-site clinical governance development day on 12 September as part of this process (to be repeated on a quarterly basis), which afforded a good opportunity for shared learning and understanding across medical, nursing and allied professional staff.

Enhancing communications within the division has been the focus of particular attention. Middle managers now visit wards and observe safety huddles and discuss issues of concern with staff. Medicine as a division received the highest score for staff engagement as part of IRIS, and 'Patient First Star Awards' have been introduced to celebrate staff who provide great patient care.

3.3.1 Self-assessment against maturity matrix core elements

Implementing best practice (e.g. NICE guidelines)

Firm progress has been achieved in that there is evidence that new national best practice is being systematically addressed and adopted. The risk register is being used proactively to capture any gaps in compliance, and appropriate action plans are in place by way of mitigation.

CQC Regulation

Firm progress has been achieved in that detailed improvement action plans have been developed and implementation is being systematically monitored and managed. Issues are shared within the division as points of learning and a Trust-wide rolling programme of peer review is in place.

Risk management

Developing progress has been achieved by the divisional leadership in establishing a system whereby risks are being consistently reviewed and calibrated, with action plans being drawn up. The risk register is systematically reviewed at monthly meetings, and evidence exists of risk informing quality improvement activity.

Patient safety and managing incidents

Firm progress has been achieved. SI investigations are competently managed within agreed timescales. Quality checks are systematically performed in respect of incident action plans, and staff attend patient safety training.

Patient and carer feedback

Developing progress has been achieved in that specific patient and carer groups within the division have been identified. There is evidence that both positive and negative patient stories are considered as part of the Division's wider learning. Complaints are dealt with systematically, with more than 50% of complaints being responded to within agreed timeframes.

Improvement, implementation and lessons learned

Firm progress has been achieved. Evidence exists of regular staff meetings and forums at which time is dedicated to learning: sharing lessons learned and discussing changes to clinical practice. Open and transparent communication channels exist to allow staff to surface improvement ideas which are then discussed more widely within the division.

Clinical audit

Developing progress has been achieved in that an overall clinical audit plan has been developed (balanced between local and national audits) as part of an improvement work programme, which is used to disseminate learning. It is anticipated that firm progress will have been achieved against this element within 6-9 months.

Mortality

Firm progress has been achieved in that all deaths are reviewed by the MDT at a dedicated session. Summary statistics received from the Trust are comprehensively reviewed. Nationally recognised measures are used to evaluate the quality and preventability.

3.4 Specialist Services

The division has produced an organogram showing how clinical governance operates at the directorate level, which could be usefully adopted as a template by other divisions. It was confirmed that the division and the four directorates (Cardiovascular; Critical Care; Trauma and Neurosciences) were using the new clinical governance templates for meeting agenda and reports which had been generally welcomed by staff as giving greater structure and focus to meetings.

With regard to overall risk management, the division had a total of 40 risks all of which had action plans in place for mitigation. A local database had been developed in respect of SIs and Duty of Candour disclosure monitoring, which represents best practice and which could potentially be adopted Trust-wide.

3.4.1 Assessment against Maturity Matrix core elements

Implementing best practice (e.g. NICE guidelines)

Mature results are being achieved through the application of best practice guidelines, which are systematically being monitored and discussed. Learning points are shared both within the division and across other clinical areas. Strong evidence exists of positive clinical outcomes for patients as a result of the consistent adherence and application of national guidelines.

CQC regulation

Results are being achieved in that compliance reviews include an external element to the division. Evidence exists of inter-division/specialty sharing of improvement points.

Risk management

Firm progress has been achieved by the divisional leadership in establishing a proactive system of risk identification which forms a key part of the annual business planning and quality assurance cycles. There is a good understanding of the wider Trust risk management system and how the division feeds into this.

Patient safety and managing incidents

Results are being achieved with improvement examples being routinely discussed and shared within the division and more widely. There is evidence that Duty of Candour compliance is robust and SI investigations are up to date.

Patient and carer feedback

Results are being achieved in that specific improvements have been made as a consequence of direct patient and carer feedback. The division is proactive in incorporating broad themes from patient and carer feedback into its improvement plans, and shared learning is strong.

Improvement, implementation and lessons learned

Firm progress has been achieved. Evidence exists of regular staff meetings and forums at which time is dedicated to learning: sharing lessons learned and discussing changes to clinical practice. Open and transparent communication channels exist to allow staff to surface improvement ideas which are then discussed more widely within the division.

Clinical audit

Results are being achieved related to the quantifiable benefits arising out of clinical audit activity (e.g. improved compliance, better use of resources, care pathway modifications). Tangible evidence exists of the connection between clinical audit and clinical governance mechanisms.

Mortality

Results are being achieved. There is evidence that changes in clinical practice are routed back to case reviews, with action plans in place to identify learning issues, both from within the division and more widely.

3.5 Surgery

Surgery is one of the largest divisions, with four directorates. The new clinical governance framework has been embedded, with the leadership in Surgery being positive about the new structure and processes, especially risk management.

The division is applying the new quality governance templates in respect of meetings which has provided more focus and concentration on key issues. Consideration is being given to the appointment of a dedicated clinical governance co-ordinator to ensure consistent adherence to the new framework and protocols division-wide.

The division is using a new online FFT system which has markedly increased responses in recent times and which is regarded as a very good feedback development by staff.

3.5.1 Assessment against Maturity Matrix core elements

Implementing Best Practice (e.g. NICE guidelines)

Developing progress has been achieved in that there is evidence that processes are in place to alert staff to new national guidelines. Gap analysis is performed, and processes for measuring and monitoring best practice have been identified.

CQC regulation

Developing progress has been achieved in that the division has mapped its compliance against all relevant standards and is aware of any gaps. There is evidence of a good level of staff engagement with this process and some dynamic performance measures are in place. A quality dashboard has been developed.

Risk management

Results are being achieved by the divisional leadership in that no risks are overdue for review on the risk register. Evidence exists that the risk system is being used proactively to identify issues that can improve patient care. Staff can articulate the top risks within the division and what actions are being taken to mitigate these.

Patient safety and managing incidents

Results are being achieved with improvement examples being routinely discussed and shared within the division and more widely. There is evidence that Duty of Candour compliance is robust and there are no out of date SI investigations exist.

Patient and carer feedback

Developing progress has been achieved in that specific patient and carer groups within the division have been identified. There is evidence that both positive and negative patient stories are considered as part of the division's wider learning. Complaints are dealt with systematically, with more than 50% of complaints being responded to within agreed timeframes.

Improvement, implementation and lessons learned

Firm progress has been achieved. Evidence exists of regular staff meetings and forums at which time is dedicated to learning: sharing lessons learned and discussing changes to clinical practice. Open and transparent communication channels exist to allow staff to surface improvement ideas which are then discussed more widely within the division.

Clinical audit

Developing progress has been achieved in that an overall clinical audit plan has been developed (balanced between local and national audits) as part of an improvement work programme, which is used to disseminate learning. It is anticipated that firm progress will have been achieved against this element within 6-9 months.

Mortality

Firm progress has been achieved in that all deaths are reviewed by the MDT at a dedicated session. Summary statistics received from the Trust are comprehensively reviewed. Nationally recognised measures are used to evaluate the quality and preventability.

4. Conclusions

4.1 Any rapid review is a snapshot in time. We have been impressed by how smoothly the Trust has transitioned to a new divisional and directorate structure, which is embedding well. The new quality and clinical governance framework designed to support the new structure has been universally adopted by divisions, and strenuous efforts have been made by the triumvirates to make the new framework work in practice and to be clearly understood by staff.

4.2 We have witnessed substantial commitment by all divisional management teams to adopt new ways of working and reporting with regard to the new framework. All divisions have welcomed the clearer and more structured approach to discussion, reporting, and escalation at quality and governance meetings, which is being mirrored by directorates. A new rhythm and structure to meetings is in place with a firm accent on the quality of patient care.

4.3 The quality of communication flow and direction from senior leadership and the centre has markedly improved in recent times, especially with regard to issuing clear and consistent guidance on clinical governance matters. A commitment to a genuine two-way communication flow in further strengthening relationships with the divisions exists.

4.4 A common matter reported to us by divisions, which it is believed would enhance quality and clinical governance Trust-wide, is for consideration to be given to the creation of local clinical governance co-ordinators (or equivalent). The establishment of these posts would, we believe, have the added benefit of enhancing information flow and communication with the centre and improve quality reporting and assurance generally.

4.5 In summary, the new quality and clinical governance framework has been adopted by all divisions and has embedded well, giving greater structure and focus to the sharing of information and points of learning. Much evidence exists that that divisions are continuing to make sustained progress in enhancing their quality and clinical governance mechanisms to the benefit of patients.

4.6 As part of best practice self-reflection, we would recommend that all divisions review their current quality and clinical governance matrix scores in a further six months' time, which should be reviewed by the Quality Governance

5. Acknowledgements

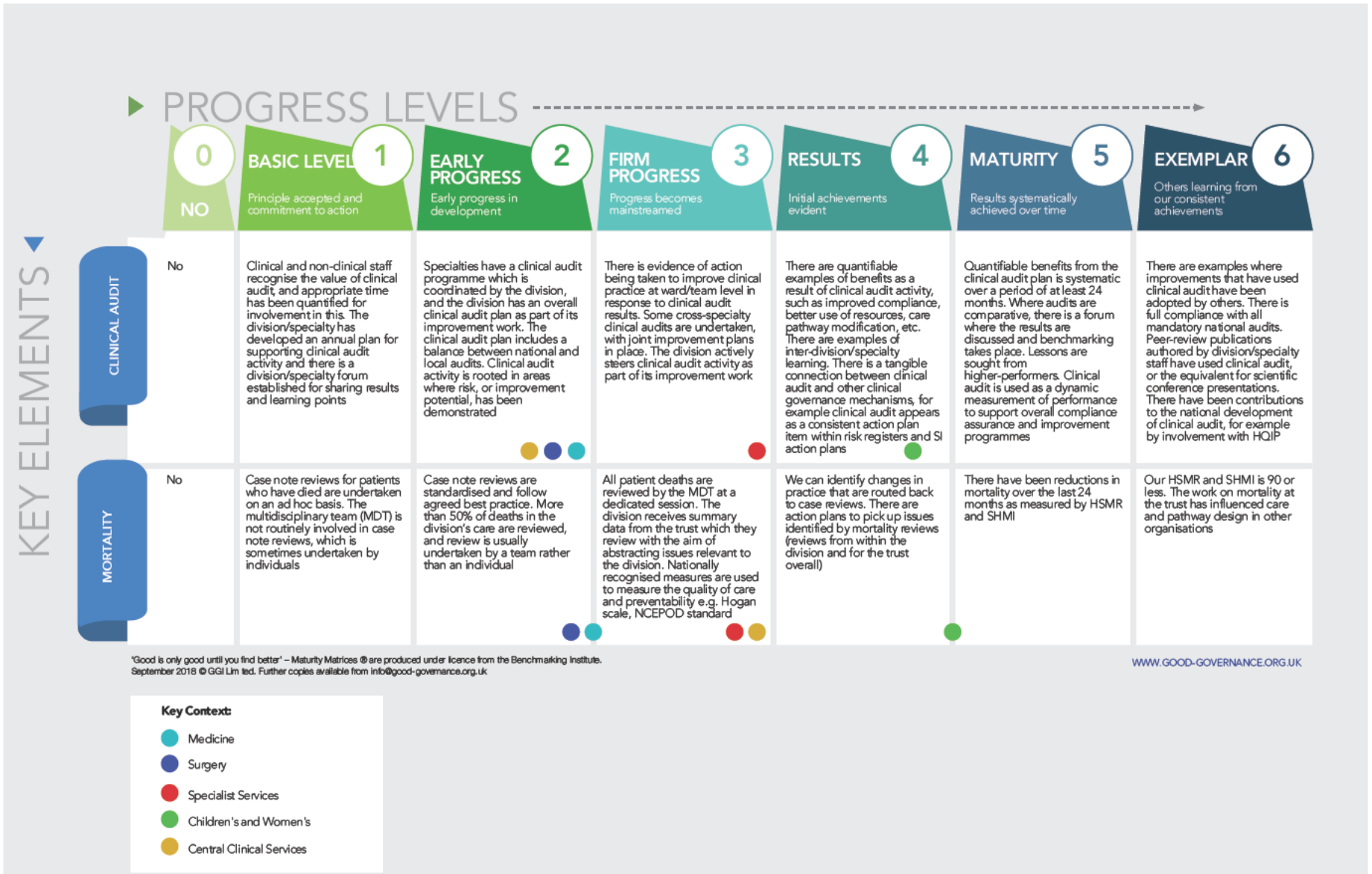
The review team would like to thank all divisional and Trust staff who gave so freely of their time and contributed so openly to the review process.

Annex 1. Maturity matrix to support the development and improvement of quality and clinical governance

PROGRESS LEVELS

KEY ELEMENTS

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 SAFETY AND MANAGING INCIDENTS	No	Incident reporting is 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. There exists evidence of staff reporting incidents of moderate harm and above. A review of incident reports is a standing agenda item at divisional and specialty level clinical governance forums	Evidence of reporting high numbers of no and low harm incidents. With only a few exceptions, incidents are reviewed within policy timescales. Duty of Candour discussions are evidenced. Staff know about 'learning from incidents' events / communications. Serious Incident (S) investigations are often overdue. Further information requests are frequently received back from commissioners	Quality checking for completion of action plans for incident reports. Feedback is provided to staff on actions arising from incidents. Staff routinely attend patient safety training. Incident reporting is not dominated by one staff group. 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 are available. Lessons learnt from incidents are discussed and shared across divisions / specialties. Broader local and national patient safety intelligence is considered. Duty of Candour compliance is tested routinely. No out of date SI investigations exist within the division/specialty. NRLS reporting is in the upper quartile	Staff are systematically involved in peer learning exercises within the trust and externally. Examples of harm reduction are demonstrable. Examples of patient/carer involvement with patient safety initiatives are available within the last 12 months. There are no breaches of internal SI deadlines in the 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 are externally shared. Staff routinely participate in broader local and national learning around patient safety. Peer recognition exists around patient safety initiatives
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 response time often falls 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 the agreed timeframe	Division / specialty complaints and PALS reviews 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 the agreed timeframe	There are examples of improvements achieved that were initiated as a result of patient or carer feedback. Broad themes identified from patient and carer feedback are included in division/specialty improvement plans. Feedback concerns are shared across divisions and specialties. When asked, front line staff can recall examples	Improvement plans are systematically checked against, and generated by, patient and carer feedback mechanisms. Improvements in examples of patient experience are demonstrable over the past 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 is included within 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 such ideas. 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 of delivering intended results. Quantifiable dividends from improvement work are 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 results 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



WWW.GOOD-GOVERNANCE.ORG.UK

www.good-governance.org.uk